

**HEALTH SYSTEM'S BARRIERS HINDERING THE IMPLEMENTATION OF  
PUBLIC-PRIVATE PARTNERSHIP POLICY IN THE HEALTH SECTOR AT THE  
DISTRICT LEVEL: A CASE STUDY OF PARTNERSHIP FOR IMPROVED  
REPRODUCTIVE AND CHILD HEALTH SERVICES PROVISION IN BAGAMOYO  
DISTRICT TANZANIA**

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## **Dedication**

To the memory of my dad

## **Abstract**

The role of the private sector in improving health systems performance in lower to middle income countries is increasingly gaining more recognition. Public-private partnership (PPP) has been suggested as a tool, to assist governments fulfil their responsibilities in the efficient delivery of health services. In Tanzania, although the idea of PPP has existed for many years in the health sector, there has been limited coordination, especially at a district level – which has contributed to limited health gains or systems strengthening obviously seen as a result of PPP. In 2009 a formal PPP policy was introduced in Tanzania, which directs the appropriate allocation of resources, and describes risk and rewards that can be achieved by building on the expertise of each partner. The Health Sector Strategic Plan III (2009 - 2015) further emphasises the need for service level agreements (SLAs), which are seen as an important indicator of improved PPP. This case study that draws on the decision-space framework, was conducted in the Bagamoyo district of Tanzania, and employed in-depth interviews, document reviews, and observations methods.

The study findings reveal several forms of informal partnerships between the local government and non-state actors. The lack of SLAs for facilities that receive subsidies from the government is argued to contribute to inappropriate distribution of risk and reward leading to moral hazards. This is evidenced by non-state actors who pursue their own interests, diverting from public social goals. Furthermore, findings highlight weak capacity of governing bodies to exercise oversights and sanctions, which is exacerbated by weak accountability linkages and power differences. Moreover, restricted flexibility in spending

is seen to deter prompt actions to address evolving population needs, given limited local fiscal space.

It is concluded that effective PPP policy implementation at a local level depends on the capacity of local government officials to make choices that would embrace relational elements dynamics in strategic plans. Disempowered Council Health Services Board in relation to engaging non-state actors is shown to impede PPP initiatives that are conceptualized at local and national levels. This study highlights a need to consider initiatives that would foster new social contracts with non-state actors at the local level and in return build a people-centred district health system.

This study is intended to improve knowledge on health systems policy interventions, strengthen future policy implementation at the sub-national level, and strengthen the district health systems as a result of PPP in a country with similar contextual elements.

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Finally, I would like to express my endless love and appreciation to my wife Sarah for her encouragement, and unwavering support. And to my son Kelvin and daughter Elsie for their love and patience, and standing my absence during my studies.

## Declaration

I, Denice Cyprian Kamugumya (KMGDEN001), hereby declare that the work in this dissertation is based on my original work (except where acknowledgements indicate otherwise) and has not, in whole or in part, been submitted towards another degree, at this University or elsewhere.

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## Contents

Dedication .....	i
Abstract .....	ii
Acknowledgement .....	iv
Declaration .....	v
Acronyms.....	viii
<b>PART A: PROTOCOL .....</b>	<b>1</b>
Introduction .....	2
Problem Statement .....	10
Study area background .....	11
Study design and justification .....	14
Methodology and data collection .....	18
Description of risks and benefits.....	21
Informed consent process.....	21
Privacy and confidentiality .....	22
Reimbursement for participation.....	23
What happens at the end of a study? .....	23
Data analysis.....	23
Research project schedule .....	24
Budget .....	25
References.....	26
<b>PART B: LITERATURE REVIEW.....</b>	<b>1</b>
Introduction .....	2
Objective of literature review .....	2
Public-Private Partnership in the health sector in sub-Saharan Africa .....	5
Strategies for Public-Private Partnership .....	10
Public-Private Partnership in Tanzania .....	14
Public-Private Partnership in historical context in Tanzania.....	16
Public-Private Partnership Policy implementation in Tanzania .....	23
Conclusion .....	27
References.....	29
<b>PART C: JOURNAL ARTICLE MANUSCRIPT.....</b>	<b>1</b>
Key messages .....	2
Abstract .....	2
Introduction .....	4



Methods .....	8
Findings .....	12
Public-private partnership and governing bodies: Challenges and limitations .....	12
Strategic decisions to improve responsiveness: Limited inclusion of actors in planning and decision-making .....	16
Performance accountability: Poor performance of accountability structures .....	20
Provision of public services: Lack of service level agreements .....	21
Discussion .....	24
Conclusion .....	29
Acknowledgements .....	30
References .....	30
 <b>Appendices .....</b>	 <b>1</b>
Appendix I (English version): In-depth open-ended Interview guide with executive key informants .....	1
Appendix I (Swahili version): Interview Questions .....	2
Appendix II (English version): Interview guide with the chairman/ secretary of the District Council Team, Ward Development Committees, and Village Health Committees .....	3
Appendix II (Swahili version): Interview Questions .....	4
Appendix III (English version): Interview guide with facility managers .....	5
Appendix III (Swahili version): Interview Questions .....	6
Appendix IV (English version): Consent Form – For Key Informants and Facility Managers .....	7
Appendix IV (Swahili version): Consent Form - For Key Informants and Facility Managers .....	10
Appendix V (English version): Consent Form – Chairman / Secretary of Committees .....	13
Appendix V (Swahili version): Consent Form– Chairman / Secretary of Committees .....	16
Appendix VI: A social network sketch (sample) .....	19
Appendix VII: Stakeholder map .....	20
Appendix VIII: Data Source .....	21
Appendix IX: Journal Author Guidelines .....	22

## **Acronyms**

ADDO	Accredited Drug Dispensing Outlets
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
APHFT	Association of Private Health Facilities in Tanzania
ARV	Anti-retroviral Drugs
CBO(s)	Community-Based Organisation(s)
CCHP	Comprehensive Council Health Plan
CCT	Christian Council of Tanzania
CDH	Council Designated Hospital
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CSO(s)	Civil Society Organisation(s)
CSR	Corporate Social Responsibility
CSSC	Christian Social Services Commission
DDH	District Designated Hospital
DED	District Executive Director
DHMIS	District Health Management Information System
DMO	District Medical Officer
FBO(s)	Faith-Based Organisation(s)
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
KM	Kilometre
LMICs	Lower to Middle Income Countries
MAT	Medical Association of Tanzania
MDGs	Millennium Development Goals
MFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
NGO(s)	Non-Governmental Organization(s)
NBS	National Bureau of Statistics
NHIF	National Health Insurance Fund
NSGRP	National Strategy for Growth and Reduction of Poverty
PFP	Private For-Profit
PI	Principal Investigator
PMO	Prime Minister's Office
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government

PMTCT	Prevention of Mother to Child Transmission
PMTI	Private Medical Training Institution
PNFP	Private Not-For-Profit
PO	President's Office
PPP – TWG	Public-Private Partnership – Technical Working Group
PPP	Public-Private Partnership
PRINMAT	Private Nurses and Midwives Association of Tanzania
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Services
SLA(s)	Service Level Agreement(s)
SSA	Sub-Saharan Africa
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for AIDS
TEC	Tanzania Episcopal Conference
TIC	Tanzania Investment Centre
TSH	Tanzania Shilling
UNFPA	United Nations Populations Fund
US\$	United State Dollar
VPO	Vice President's Office
WDC	Ward Development Committee
WHO	World Health Organisation

# **PART A: PROTOCOL**

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**Health System's Barriers Hindering Implementation of Public-Private Partnership: A  
Case Study of Partnership for Improved RCHS Provision in Bagamoyo District Tanzania**

## Introduction

Tanzania is one of the lower to middle income countries (LMICs) that has recently experienced sustained economic growth, amidst political stability. The average Gross Domestic Product (GDP) growth per annum is estimated at 6.9% that is coupled with low inequality, with a GINI co-efficiency of 37.6 (IMF 2010). In 2011, the GDP per capita was 609 US\$ (World Bank 2012). This economic development has not translated into substantial health gains as the country is still experiencing several challenges that contribute to poor health outcomes (World Bank 2011). For example, non-communicable diseases are emerging in the midst of the challenges observed in tackling communicable diseases (Maletnlema 2002) posing further challenges to an already overstretched health system.

At present, the Government of Tanzania is implementing the Health Sector Strategic Plan III (2009 - 2015), which was developed in line with the National Strategy for Growth and Reduction of Poverty, and the Millennium Development Goals (see MoHSW 2009; Musau et al. 2011). It recognises the important role of public-private partnership (PPP) in efficient delivery of social services through the concept of complementarity, stating that, 'stakeholders in health have distinct competencies, which have to be used optimally, avoiding overlaps, gaps and unnecessary competition', setting a stage in addressing a complex range of factors that underpin health service delivery (MoHSW 2009).

The partnership as stated in the national PPP policy entails, 'the arrangements between the government and private sector entities whereby the cooperation may involve renovation, construction, maintenance, management and provision of services in a whole

or in part, in accordance with specified outputs' (PMO 2009). In Tanzania, the health sector non-state actors provide a wide range of services ranging from preventive, curative to rehabilitative and in some areas are involved in pre-service training, pharmaceutical supply, and construction and maintenance of facilities (White et al. 2013). The private sector in Tanzania includes, a significant number of private not-for-profit (PNFP) providers usually, faith-based organisations (FBOs), as well as voluntary community-based organisations (CBOs), private for-profit (PFP) providers, civil society organisations (CSOs), international non-governmental organisations (NGOs), and companies' corporate social responsibility (CSR) (Figure I).

Health Sector Landscape in Tanzania			
Public Health Sector		Private Health Sector	
MoHSW PPP unit PPP – TWG	Prime Minister’s Office (PMO) (PPPs and TIC)	<b>PNFP Sector</b>	<b>PFP Sector</b>
MoHSW Training Centres Teaching Hospitals Medical Universities	Ministry of Finance and Economic Affairs (PPP Unit)	FBOs (Medical Services)	Health Facilities / Healthcare providers Individually owned or Under organisation
	Ministry of Education (Training centres)	NGOs (Medical Services)	
PMO – RALG Regional / District Health Management Teams Regional hospitals Public health facilities		NGOs and FBOs (Non-Medical Services)	Diagnostics (Laboratories, radiology and other tests)
		NHIF/CHF	FBO – PMTI
	Associations Health Professional Associations (MAT, and PRINMAT) APHFTA Pharma Mfg Association		Health insurance
		Development partners/ International NGOs	
		CSOs	

**Figure I:** Drawn by the author with inputs from White et al. (2013)

The history of private providers in the health sector can be traced back from early 1960s, a time when faith-based providers in particular were well established before

independence from colonial administration in 1961. Changes in the national social and economic policies to socialist ideology in late 1960s and in 1970s affected the scope of social services provided by non-state actors, especially the FBOs (Leurs et al. 2011). It included limiting the role of private providers, and in some areas, services were nationalized (see Leurs et al. 2011; Munishi 1997). Faith-based providers that remained prominent after independence were categorized as PNFP (Leurs et al. 2011), while PFP providers were banned in late 1970s, but later re-introduced in early 1990s following the country's macro-economy reforms (Due 1993; Munishi 1997). The liberalization of economic policies in 1990s also contributed to the increased scope of services offered by FBOs as the government continued to rely more on their services in order to bring about the required development changes (Leurs et al. 2011). With the increase in HIV burden, and need for Reproductive and Child Health Services (RCHS), several local and international NGOs are now also involved in service delivery, logistics and supply of commodities, and training of health workers country-wide (see Musau et al. 2011; White et al. 2013; World Bank 2011). More so, facility-based private providers are becoming widely relied upon by the public given perceptions of relative better quality of services or being the only services available within reach (see Kruger et al. 2013; Mtei et al. 2012).

Private-for-profit providers under coordination of the Association of Private Health Facilities in Tanzania (APHFTA) at the national level are more concentrated in urban areas, providing estimated 19% of national services, and largely at the dispensary<sup>1</sup> level (see Benson 2001; Makawia et al. 2010; Mtei et al. 2012; MoHSW 2009; White et al.

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<sup>1</sup> Dispensaries are the lowest and the first point of primary care in Tanzania referral system (Figure II). For public-owned facilities, a dispensary serves a respective village population.

2013). Faith-based providers under the umbrella of Christian Social Services Commission (CSSC) at the national level, and other faith-based and voluntary providers account for an estimated 15% of facility-based providers (Makawia et al. 2010). These figures do not include non-facility-based services such as pre-service training, health insurance, and commodity supplies (White et al. 2013). PNFP providers account for more than 50% of all hospitals and about 3% of health centres (White et al. 2013; Makawia et al. 2010). In districts with no public owned hospitals, faith-based hospitals have been accredited as Council Designated Hospitals (CDH). In total, there are 34 CDH across the country (White et al. 2013). The government remains the main facility-based provider accounting for 65% (Makawia et al. 2010) even though most of public facilities are faced with challenges such as shortage of supplies, and skilled and motivated staff (see MoHSW. 2008a; Makawia et al. 2010; Kwesigabo et al. 2012; Rolfe et al. 2008).

Although the idea of PPP has existed for several years, it can be argued that there was no effective formal coordinating mechanism for PPP. This has contributed to limited health gains, and further health systems weakened by weak accountability, inadequate human capacity, unclear staff role and responsibilities, existence of vertical health interventions with weak coordination, and inability to prioritize the use of resources (see Musau et al. 2011). The national PPP policy that was introduced in 2009, followed by the PPP Act in 2010, both describes how resources, risk and rewards can be appropriately allocated by building on the expertise of each partner (see Africa Health 2012; MoHSW 2009; PMO 2009). The Health Sector Strategic Plan III (2009 - 2015) further emphasises the need for service level agreements (SLAs), which are formal contracts between District councils and non-state actors, aiming at providing mutual benefits to both entities, and facilitate



access to public resources by private providers. SLAs offer an opportunity for regulated collaborations, and are an important indicator of improved PPP (MoHSW 2009).

The importance of PPP to attain equity, quality and efficiency of the health system can be seen in four different ways. Firstly, PPP has a potential to improve mechanisms of resource sharing at the district level for situations like referrals and the use of medical technology. For example, it has been argued that in the implementation of SLAs for faith-based providers who receive subsidies from the government, an effective allocation of resources and collaboration is still lacking (see Itika et al. 2011; Makawia et al. 2010; Musau et al. 2011). In other settings, there are missed opportunities for SLAs where available resources could be shared between the government and private providers (White et al. 2013), contributing to the poor performance of the health system.

Secondly, PPP has the potential to extend the reach of health services to the most underserved communities given resource constraints facing the Government, and the national dependency on external financial support of the health sector. In Tanzania, external source of funds contributes 40% of the total health expenditure (WHO 2011), which supports local governments through a basket fund (Word Bank 2011). Additionally, out-of-pocket payments contribute significantly to the health system financing, accounting for 32% of the total health expenditure (Mtei et al. 2012). A significant amount of out-of-pocket payment happens in the private sector as 'PFP and PNFP facilities account for 11.2 and 19.9 percent of the total health expenditure made at facilities respectively', which does not include payments made to pharmaceutical outlets (White et al. 2013). Effective mechanisms for partnership with private providers should

limit financial burden to most vulnerable individuals, and reach those with most need. Although mechanisms are in place to exempt the vulnerable groups such as pregnant women, under-five children and elderly, this mostly applies to PNFP providers as stipulated in their SLAs, and all public facilities (see Makawia et al. 2010; Mtei et al. 2012). For PFP facilities, which are often the only facility with superior quality of services in a given geographical area, fee exemptions do not apply (see Mtei et al. 2012; White et al. 2013), even when medical supplies in public facilities are out-of-stock, which is usually the case in several occasions (see Musau et al. 2011; Mtei et al. 2012; Makawia et al. 2010; World Bank 2011). Furthermore, SLAs with accredited providers for the Community Health Fund (CHF), which is a voluntary pre-payment social protection scheme at a district level that was introduced targeting 85% of the population in rural areas, and those employed in informal sector, are restricted to only selected PNFP providers (see Kamuzora et al. 2007; Mtei et al. 2012). This gap in effective allocation of resources to reach the most in need, indicates the importance of establishing an effective mechanism to work with all types of private providers to achieve a wider social value, particularly at times when public facilities have a shortage of supplies.

Thirdly, PPP is seen to be able to address the rural and peri-urban local need, for pharmaceuticals and medical supplies. In this regard, the government has engaged PFP and PNFP providers to complement public services in underserved areas (see Centre for Pharmaceutical Management 2008). Privately operated Accredited Drug Dispensing Outlets (ADDOs) known as essential drug shops are now in operation country-wide (Musau et al. 2011; Centre for Pharmaceutical Management 2008). Even though the ADDOs were introduced to address the health system challenges such as 'affordability,

availability, acceptability, and geographical accessibility of essential medicines' (Centre for Pharmaceutical Management 2008), there are gaps that are yet to be addressed such as lack of standardization on how to operate the shops, and lack of quality assurance (see Musau et al. 2011; White et al. 2013).

The inability of local governments to track and compare price differences that are not attributed to local cost factor has implication on the quality of services offered and on equity (see Makawia et al. 2010; Musau et al. 2011; White et al. 2013). This also provides a room for fraud in procurement, which could be the source of poor quality medication, and contributing further to unresponsive health system (see Savedoff et al. 2008). At the national level, the CSSC (the network of faith-based health and education providers) initiated a network of church-owned providers that purchase pharmaceuticals from one wholesaler at a reduced price, which enables provision of affordable care at their facilities (Centre for Pharmaceutical Management 2008; White et al. 2013). This aspect of pharmaceutical reforms that promote private sector activities could lead to 'political patterns of collaboration, competition, and conflict' (see Reich 1995), which if not well coordinated may further weaken the health system.

Fourthly, partnership is seen to be able to improve health system responsiveness to local need. It can be argued that the effective information and data flow from private providers and the use of the same in decision-making such as reviewing and negotiating SLAs at the district level is expected to heighten responsiveness (see Brinkerhoff 2004). The revised District Health Management Information System (DHMIS) has incorporated the requirement for non-state actors to submit their health information to the district

authority (see Musau et al. 2011), however within Tanzania health sector, several limitations in obtaining information from private providers have been observed mainly contributed by accountability structures, and distrust between public and private providers (see Itika et al. 2011; Musau et al. 2011; White et al. 2013). Such a gap is likely to be addressed by relationships established with shared values, and by considering the changing value-base of society (see Gilson 2003).

The health system in Tanzania is decentralized with the Ministry of Health and Social Welfare (MoHSW) providing a leadership and stewardship role and District local governments undertaking an operational function (MoHSW 2009; TACAIDS 2012). The decentralized system underscores the importance of effective PPP mechanisms that would make services available to underserved communities and population at large, and impact on efficient, equity and quality of services delivered by the district health system. On the other hand, the effective implementation of PPP policy in the health sector using various mechanisms such as accreditation and licencing, contracting-out, franchising social marketing, voucher scheme, and concession (see Marek et al. 2005; Patouillard et al. 2007), is highly dependent on the robustness of the health system (see Palmer et al. 2006; Ravindran 2010) both at district and national levels, which is expected to further strengthen health systems as a result of PPP.

The decentralized system provides autonomy for each district to develop and manage its own Comprehensive Council Health Plan (CCHP), which has to be in line with the national priorities (MoHSW 2009), providing a room for a range of choices that can be made to improve performance by working with non-state actors at the local level (see Bossert

1998). Inadequate capacity to coordinate resources, identify effective technical strategy and scale-up effective interventions, and poor managerial practices, have been indicated to underlie the slow progress in improving overall health system's performance, (see Buse et al. 2009; Kamuzora et al. 2007; Musau et al. 2011; White et al. 2013). Thus, understanding health system's barriers to the effective implementation of the PPP policy in the health sector at the district level would be a starting point to gain insight on how district health systems can be strengthened.

## **Problem Statement**

In Tanzania, at a district level, PPP is still a new concept in the health sector despite the long-term presence of multiple non-state actors (Itika et al. 2011; Musau et al. 2011; White et al. 2013). A recently established PPP unit, and PPP-Technical Working Group within the MoHSW at the national level, are spearheading the implementation of a new PPP policy, and provide technical coordination at the national level (Africa Health 2012). At the district level, however, this would depend on the district health system governance and the presence of appropriate competencies that would facilitate planning and policy dialogue, and improve on how SLAs are initiated and executed with various local actors (see Bossert 1998; Brinkerhoff 2004). Limited local capacity in terms of decision-making and accountability might restrain the progress on PPP given the widespread nature of services to be rendered and its socio-political complexity. This study seeks to explore possible barriers that hinder the implementation of the PPP policy in the health sector at the district level.

## Study area background

Bagamoyo district, in the Eastern zone of Tanzania was selected for the site of this case study based on the characteristics of the population, which is an urban-rural mix, and the presence of multiple non-state actors who are engaged in providing RCHS. Additionally, the area is known by and accessible to the researcher, matching the time and financial limitations. Bagamoyo district is situated 75 km North of Dar-es-Salaam, the main business and trading city in the country. Therefore, it is not representative of more remote districts. However, by considering the uniformity of the district's governance structure across the country, and the nature of non-state actors (Figure II), this district should still provide insight relevant to other districts in Tanzania.

Bagamoyo district is one of 169 districts in Tanzania, and one of six districts in Pwani region (NBS 2013). The district has a population of 311,740, with 154,198 male and 157,542 female, and population density of 36.8 per km<sup>2</sup>. The annual population growth rate is estimated at 2.2. The district is divided into, six (6) administrative divisions and 22 wards with an average household size of 4.1 (NBS 2013). There are two parliamentary constituencies in the district which are Bagamoyo and Chalinze, with Bagamoyo town being the district capital (Bagamoyo District 2009).

As Figure II depicts, the district is governed according to the Local Government (District Authorities) Act 1982, with the District Commissioner, which is a presidential appointment, executing all executive functions of the government at the district level. The head of district social services and development initiatives is the District Executive Director (DED) who is appointed by the Minister responsible for the Regional

Administration and Local Government. Under the DED are several heads of departments, including the District Medical Officer (DMO). Public representation at the district level is through the District Council Team, which is formed by elected councillors, and led by the Council Chairman. At the Village level, the elected Village Chairman provides leadership and is assisted by the Village Executive Officer who is appointed by the local government. Each village has its own government that is divided into five committees each responsible for specific functions, such as health, education, and alike. The wards are governed by the Ward Development Committees (WDC).

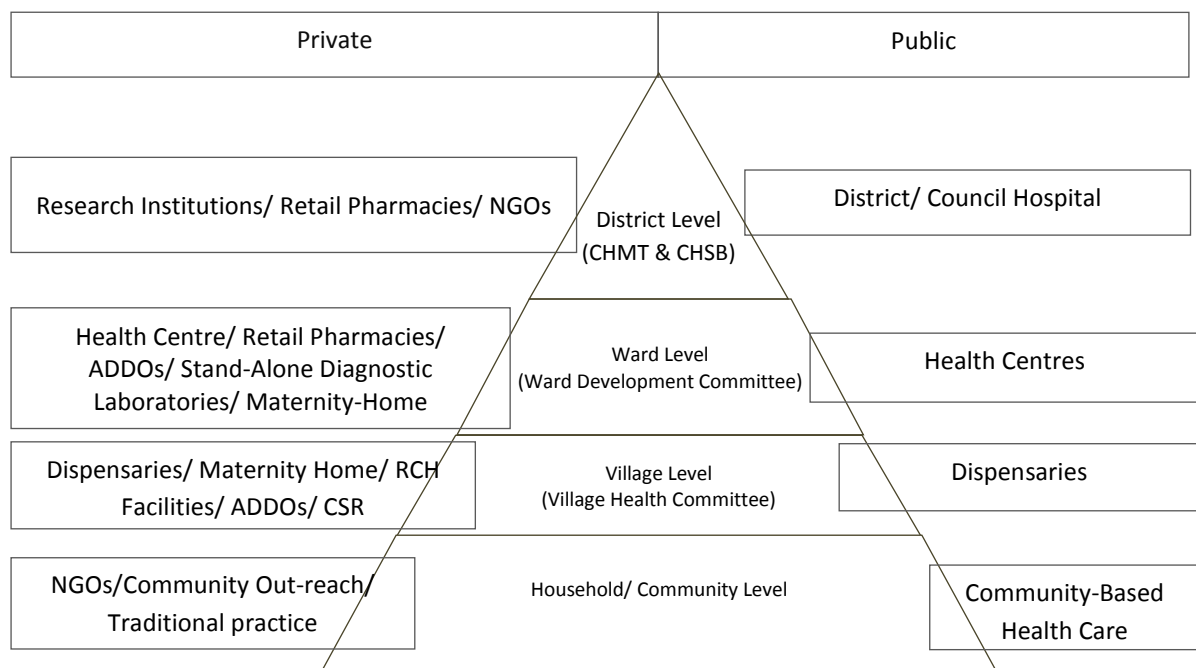
The district health system (Figure II) is managed by the DMO who is the head of the Council Health Management Team (CHMT) and seats in the Council Health Services Board (CHSB) meetings as a secretary (MoHSW 2009). The Bagamoyo district hospital is public owned and the only hospital in the district, and is located on the periphery of the district, somewhat isolated from the rest of the district due to poor road conditions (Bagamoyo District 2009). At the dispensary<sup>1</sup> level, there are 41 public facilities, 11 PFP facilities, and five (5) PNFP (voluntary) facilities across the district while at the level of the health centre<sup>2</sup> there are four (4) public facilities, and one (1) PNFP facility (MoHSW 2014). Other than these facilities, the other parties engaged in RCHS in the district include companies through their CSR, and NGOs (see Mallya et al. 2011).

The procurement of pharmaceutical and medical supplies at the district level is coordinated by the District Pharmacist - however this does not include private facilities,

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<sup>2</sup> Health Centres serve as referral facilities for dispensaries (Figure II). For public-owned facilities, a health centre serves a respective ward population.

pharmacies or retail pharmaceutical outlets (see Centre for Pharmaceutical Management 2008; MoHSW 2009). Private pharmacies and ADDOs are guided by the Food, Drugs and Cosmetics Act (2003) and Pharmacy Act (2002). Shortage of supplies is sometimes experienced at public facilities necessitating individuals to purchase items from private providers at the market price where in some cases expired items are sold-out (see Mallya et al. 2011).



**Figure II:** The District Governing Structure and Non-State Actors in the Health Sector.

*Modified by the author from White et al. (2013)*

The recruitment of staff for public facilities is centrally coordinated, with the district sending their request to the MoHSW through the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) (MoHSW 2009). The Private Hospitals Act of 1991 and the Private Health Laboratories Regulation Act of 1997 guide private



providers in this part, in some facilities however, inadequate trained staff provide services (see Itika et al. 2011). Other challenges facing Bagamoyo district are availability of clean and safe drinking water, poor urban planning, poor infrastructure, and communicable diseases such as malaria and HIV/AIDS (Mallya et al. 2011; Sosovela 2009). It is estimated that approximately 15% of deliveries are assisted by trained traditional birth attendants, while about 13% are conducted by unskilled person in the region (NBS and ICF Macro 2011). The HIV prevalence in the region is estimated to be 5.9%, which is slightly higher than the national average (TACAIDS 2013). Transformation of the district to a tourist hub, largely contributed by cultural museums, beach, and conference centres has stimulated economic development opportunities, bringing in new socio-economic challenges to already overstretched social system (Mallya et al. 2011).

## **Study design and justification**

Implementation of the PPP policy in the health sector at a district level involves multiple stakeholders (see Rosen 2000; White et al. 2013), and context specific factors that influence social actors' interaction can be well demonstrated and understood using a case study (Russell 2005). Likewise, Thomas et al. (1998) have demonstrated that the case study can provide understanding of a complex reality that cannot easily be measured. In this study, a single site case study will be used as an 'instrument to gain a broader understanding and appreciation' (Crowe et al. 2011) of the PPP policy implementation in the health sector at the district level.

In order to understand multiple factors underpinning the PPP policy implementation in the health sector in its real life context (see Crowe et al. 2011), the provision of RCHS will

be used as a context. RCHS are considered as essential public services, involve multiple expected implementing partners, and some of the RCHS provided by private providers are expected to be free of charge to users. The RCHS encompass initiatives such as family planning, safe motherhood, immunization, gender-based violence, male involvement, PMTCT, youth-friendly initiatives, and prevention and management of childhood illnesses, all of which are not only provided by public facilities in Tanzania (see MoHSW 2008b; White et al. 2013).

Scaling-up of RCHS to areas which are underserved is one of the MoHSW priorities (see MoHSW 2008b; MoHSW 2009). This includes improving, 'availability of family planning commodities and the use of modern family planning methods, access to PMTCT services, uptake of antenatal care, the immunization coverage, under-five nutrition status, proportional of deliveries by skilled attendant, and availability of Basic and Comprehensive Emergency Obstetric Care' (MoHSW 2008b). The Health Sector Strategic Plan III (2009 - 2015) has highlighted the role of non-state actors in attaining these objectives, which signifies the need for performance-based contracting and taking into account contextual factors when initiating and implementing SLAs (see Savedoff et al. 2008). For example, limited resources and challenging environment where non-state actors operate might contribute to inadequate or low quality of service delivery (see Kruger et al. 2013; Rolfe et al. 2008). Likewise, training of traditional birth attendants, and setting up of nursing and maternity homes, which are privately operated, in different localities across the country, has been recognised to contribute to better health outcomes, (see MacLeod et al. 1998; Magoma et al. 2010; Rolfe et al. 2008), however this can be attained with enhanced accountability interactions among various actors at the

local level (see Brinkerhoff 2004). Thus, the use of RCHS provision in Bagamoyo district as a case study would make the study easily manageable in exploring the socio-political complexity of the health system that affects the implementation of the PPP policy in the health sector at the district level, and be able to establish generalizable patterns.

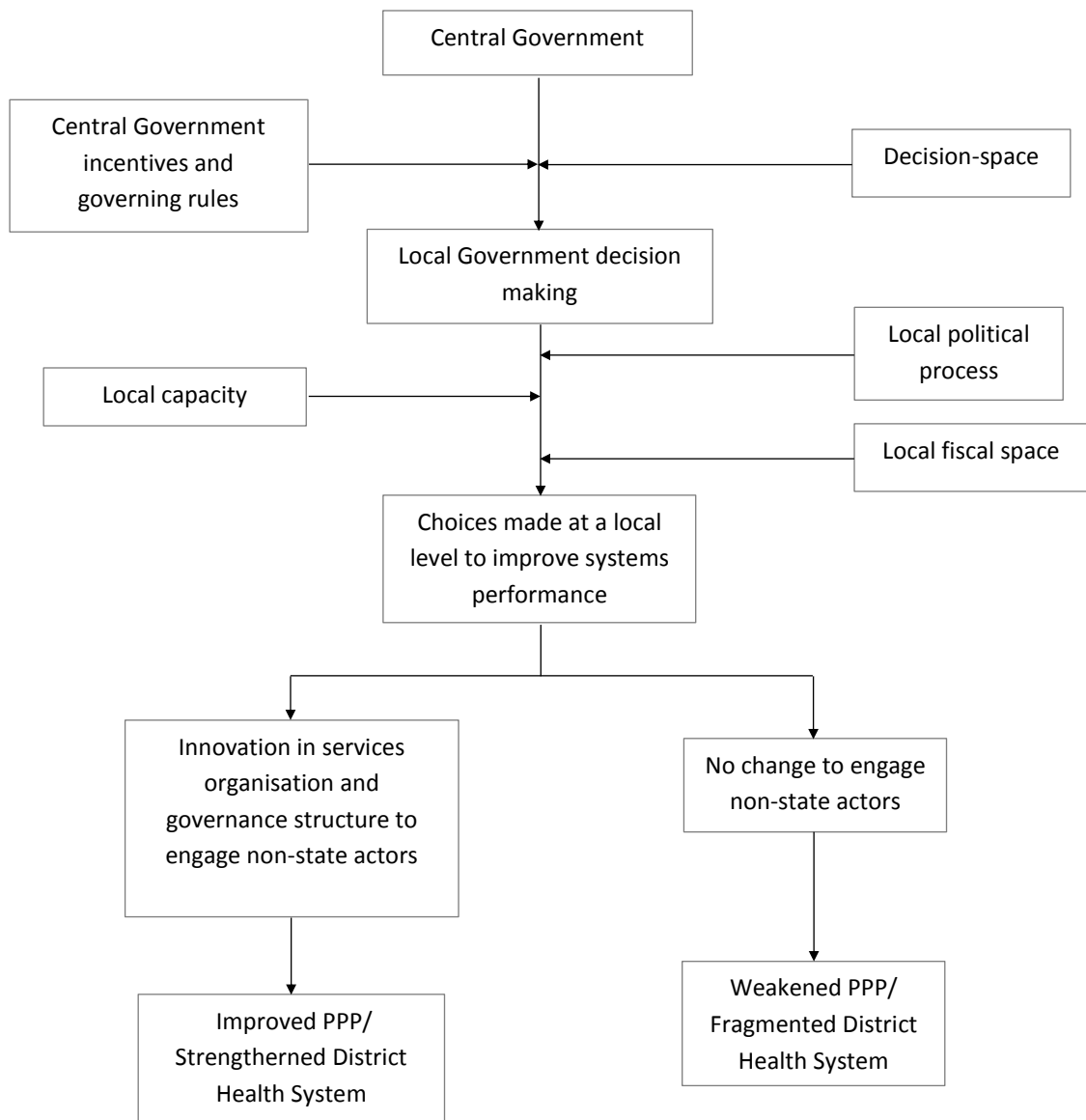
The decision-space framework by Bossert (1998) will be used to gain insight into implementation of the PPP policy in provision of RCHS, as it takes into account the principle-agent interactions in the decentralized health system (Figure III). The focus would be to explore systems' barriers under governance, and services organisation-actors' interactions in particular, that the district would need to engage in order to strengthen PPP at the district level, and underpin the district health system in return.

The main research question to be answered is: what are the governance-related health systems barriers that hinder implementation of the PPP policy in the health sector in Bagamoyo District of Tanzania?

The sub-questions in this case study that would guide in exploring systems barriers will focus on two aspects, actors' interactions and SLAs as related to PPP. The sub-questions to be answered are:

- Who are the key stakeholders for PPP in Bagamoyo relating to RCHS provision?
- What are the stakeholder's position, interest and influence on PPP?
- What competencies are needed for successful PPP?
- Where strong partnership does exists, is it formal or informal?

- What SLAs exist, and how were they initiated (centrally or from local government level)?
- How successful are the SLAs in practice?
- What types of PPP mechanisms as stipulated in the national PPP policy exist and how effective are they?

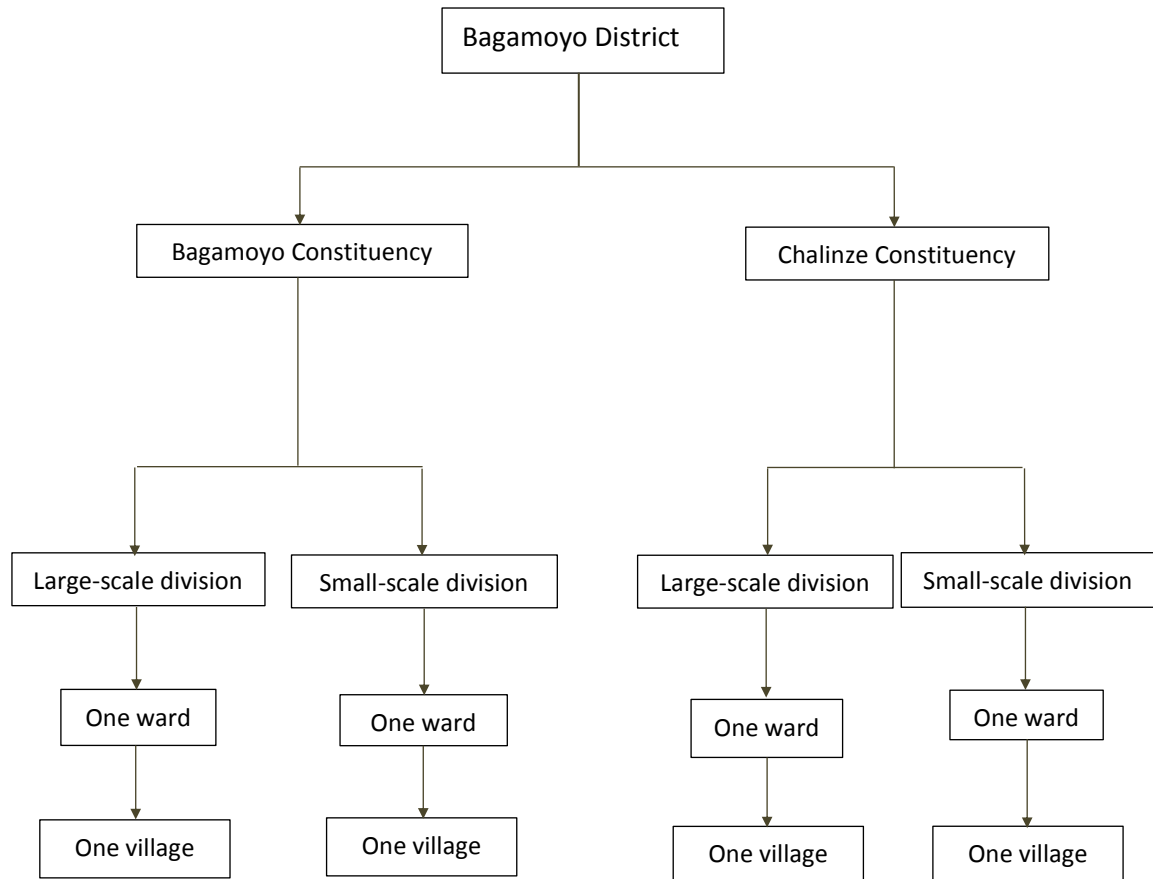


**Figure III:** Study framework (Author) with inputs from the decision-space framework by Bossert (1998)

## Methodology and data collection

The sample for this study would be purposefully selected from a stakeholder map that will be established after stakeholder analysis to ensure various key actors in provision of RCHS are included. Consideration would be given to the two parliamentary constituencies in the district which are Bagamoyo and Chalinze (Figure IV), in order to get a proper representation given political influence that shapes actors relations (see Walt and Gilson 1994). Two divisions from each constituency would be selected based on the scale of RCH initiatives in those areas, which would be determined through a document review that will include monthly, quarterly and annual reports, and the CCHP to be obtained at the office of the DMO. The four divisions selected will include one division with large-scale RCHS, and one division with small-scale RCHS, in terms of number of RCHS providers, from each constituency. One ward from each division and one village from each ward would be purposefully selected based on the scale of RCH initiatives, which would also be determined through document reviews as well as initial interviews.

The study design appreciates key actors interaction in implementing the PPP policy in the health sector while taking into account the political and organisation factors that affect the policy reform (see Bossert 1998; Brinkerhoff 2004; Reich 1995). The study methodology also draws on two previous visits to Bagamoyo district by the principal investigator (PI). The first visit was during the medical school fieldwork in 2002, and the second 2013-visit was to explore how district health systems function.



**Figure IV:** Sampling guide (Author).

The initial phase of the study will include: stakeholder analysis to identify policy actors, assessing their political resources, and understand their position and interest (see Buse et al. 2012). The identification of an initial set of key actors will be through a session that will be attended by the PPP District focal person, and the District RCHS coordinator who are the key informants in this case. The second step will consist of analysing power of each stakeholder as tangible and intangible assets would influence the PPP policy implementation. This will then be followed by assessing their interests, position and commitment to determine how their resources are deployed (see Buse et al. 2012). This will involve in-depth interviews with key informants as they get identified in the stakeholder analysis. For committees such as CHMT, CHSB, District Council Team, and

wards, and village committees, the head or chairman, and secretary will be invited for interviews. This phase will assist to determine the level of a decision-space at the local level, and how SLAs are initiated or not initiated, taking into account the local context.

The initial phase of this study will also include, document reviews, and observations by attending governance-related meetings in order to identify, and understand the role of various actors. Physical attendance to meetings would be requested from committees' leaders and/or other organisers. Document reviews and observations will assist to identify other RCHS providers who would not be mentioned voluntarily, and establish if there are SLAs that exist with the local district authority, how the SLAs are initiated, and the content of the agreement to determine how the answerability and sanction are taken into account.

This will be followed by direct observations and in-depth interviews with, managers of private providers including non-facility based services, who will be purposefully selected as guided by Figure IV. It will include four dispensaries, one health centre, one maternity home, two pharmacies, two essential drug shops, two ADDOs, two NGOs, one research institute, one private company (CSR), and two traditional practices. This phase will also explore missed opportunities for PPP in RCHS provision, supportive services inclusive, and establish accountability linkages contributing to the situation. Data will be collected until a saturation point is reached. In total, 42 interviews are estimated to be conducted but saturation point may be reached with fewer interviews.

## **Description of risks and benefits**

Potential risks anticipated from conducting interviews are those related to discussions that would focus on personal beliefs, stories and practice. To minimize the risk, consent to participate in the interview would be obtained beforehand (Appendix IV and V). Additionally, every effort would be made to put the participant at their ease, for example ensuring the location of the interview is in a quiet and private space. Interviews with key informants would bring to light complex range of factors underpinning PPP.

Other risks are those related to interviewees particularly non-state actors, mentioning something that has a potential to damage relationship with other actors. In situations where this would happen, clarification would be requested, and statements would be rephrased to focus more on accountability linkages. Respondent validation will be requested to ensure the meaning is not distorted.

Another potential risk would be attending meetings or conducting observations without prior authorization. To avoid any misunderstanding that may arise, a request to attend such meetings would be sent through appropriate channels, and all key individuals informed. Observations are likely to confirm aspects of PPP that would be mentioned during interviews, as well as identifying issues related to governance that would need further exploration.

## **Informed consent process**

Individuals who will be requested to participate in interviews would be identified by the researcher (PI) after the stakeholder analysis. Invitation to attend the interview will be



done verbally face-to-face beforehand in order to respond to questions that may arise and set a convenient date. On the day of interview, an informed consent form either an English or Swahili version would be given to the interviewee based on the preferred language. The interviewer will request that the interviews be voice-recorded. However, on refusal or if the researcher deems the voice-recorder is making the interviewee uncomfortable the interview will rely on notes only. The interviewee would be requested to sign the form if he/she accepts, or choose not to sign the form if he/she does not want, to participate. Participation in the interview will be voluntarily. Those who would participate in the interview will be given a copy of the consent form that has been countersigned by the researcher.

### **Privacy and confidentiality**

Interviews will take place in a closed room to ensure confidentiality, and only the interviewer and interviewee will attend. Voice-recording will only be initiated after an initial introduction to avoid recording personal information. All scripts will be coded, and no names or any other personal identifiers will be used in the reporting of this study unless direct permission has been given.

Scripts will be downloaded and stored in the researcher's computer until when the final report has been finalized, then will be discarded. The script file in the computer will only be accessed using a password, and the password will be accessible to the researcher (PI) only. All scripts in the recorder will be discarded immediately after downloading. The researcher will make sure he does not share any confidential information among different actors.

## **Reimbursement for participation**

There would be no incentives to participate in interviews since it is expected most interviews would take place at key informants' offices. However, at the level of wards and villages, compensation for time lost for interviewees who have other income generating activities, other than being permanent employees in a formal sector, would be considered (or allocated towards refreshments, if that is deemed most appropriate). The rate for such compensation will be TSH 10,000/- (~ US\$ 6).

Emergency events during interviews are unlikely to happen, however for those travelling to the interview site might be involved in accidents though the likelihood is rare. In case of such events the local authority stipulated procedures would be followed, which will be inquired in advance.

## **What happens at the end of a study?**

All scripts will be discarded, including notes taken during data collections. Copies of various documents such as guidelines and reports also will be discarded. Likewise, all written working documents will be discarded as well. Preliminary research findings will be presented to the DMO, and shared among the CHMT.

## **Data analysis**

All transcripts will be translated from Swahili to English. A theoretical framework (Figure III) would guide the thematic analysis process when organising the data, organizing emerging themes, representing the data, and forming interpretations. Data from each group of non-state actors would be analysed separately at the initial stage and identified

patterned regularities explored, and later data would be combined in order to understand the emerging phenomenon in the whole district.

The analysis would incorporate the stakeholder analysis, which would produce the stakeholder map at the time of study. The stakeholder map will be used to produce actors' accountability linkages matrix (see Brinkerhoff 2004). In order to improve the validity, data from all sources (interviews, observations, and document reviews) would be triangulated and themes generated. Negative trend checking and rechecking would be carried out as data will be analysed. Findings will be presented in thematic descriptions and interpretive explanations.

## Research project schedule

EVENT	MONTH										
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	
Submit the protocol to Ethics Committee	■										
Full literature review	■	■									
Applying for ethics approval in Tanzania			■								
Travel to Dar-es-Salaam			■								
Travel to the field & meeting with the District Medical Officer					■						
Meeting with RCHS Coordinator and PPP focal person					■						
Document review & Observations					■	■					
Interviews					■	■					
Data analysis						■	■				
Report writing							■	■	■		
Final report submission										■	

## Budget

This study is a self-funded research to be undertaken in the researcher's country of residence for the purpose of Master's degree. The principal investigator declares to have no conflict of interest.

Item Description	Unit (S)	Cost (USD)/ Unit	Total (USD)
<b>Pre-field expenses</b>			
Air Ticket (Return)	1	800	800
Application for Ethics Approval in Tanzania	1	150	150
<b>Sub Total</b>			<b>950</b>
<b>Field expenses</b>			
Researcher Allowance	90	56	5040
Transport Dar-Bagamoyo-Dar	30	7	210
Interviews reimbursement for time lost	16	6	96
Transcripts Translator	1	200	200
<b>Sub Total</b>			<b>5546</b>
<b>Stationaries</b>			
Pens	5	0.3	1.5
Pencils	5	0.15	0.75
Writing pads	3	3	9
Printing Consent Forms	200	0.2	40
Final report printing	2	15	30
Final report in CD	1	20	20
<b>Sub Total</b>			<b>101.25</b>
<b>Incidental Cost</b>		300	<b>300</b>
<b>Total</b>			<b>6897.25</b>
Contingency (10%)			689.725
<b>Grand Total</b>			<b>7586.98</b>

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# **PART B: LITERATURE REVIEW**

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**Attaining Health Goals through Public-Private Partnership in  
Sub-Saharan Africa**

## Introduction

The role of the private sector in improving health systems performance is increasingly gaining more recognition. This trend is more observed in countries where health services are disproportionately distributed, and public services available are of a low quality (Boulenger et al. 2009; Brinkerhoff and Brinkerhoff 2011; Buse and Waxman 2001; Ghatak et al. 2008; Gilson et al. 1994; Marek et al. 2005; Spreng et al. 2011). In the last two decades, most lower to middle income countries (LMICs) embarked in health sector reforms that were aimed at reducing the inequities, and improving efficiency and quality of care to poor people.<sup>1</sup> These reforms were directed at improving health goals, widely linking the health sector with the development and economic agendas (Green et al. 2002; WHO 2000). This is explicitly stated within internationally developed targets such as MDGs, and multilateral, bilateral and other international aid agencies' priorities (Mills 1998; World Bank 2004). However, these reforms continue to happen in unorganised health care market's environments, with features that could lead to markets failure (see Bloom et al. 2008).<sup>2</sup> It is expected that engaging the private sector in policy setting, planning, and implementation should improve efficiency of public funded services and harness the private sector resources (Palmer 2000; Spreng et al. 2011).

## Objective of literature review

This literature review was guided by three questions; why is public-private partnership (PPP) important, what PPP mechanisms are considered feasible in improving health

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<sup>1</sup> Poor people include 'people experiencing any of the many dimensions of poverty such as wealth, gender, ethnicity, people with physical and mental disability and those vulnerable or at risk of poverty' (World Bank 2004).

<sup>2</sup> The health care market will fail when 'externalities (costs and benefits) are not taken into consideration by consumers and producers', there is lack of incentive to provide many public goods, and the presence of non-state actors' monopolies (Buse et al. 2012).

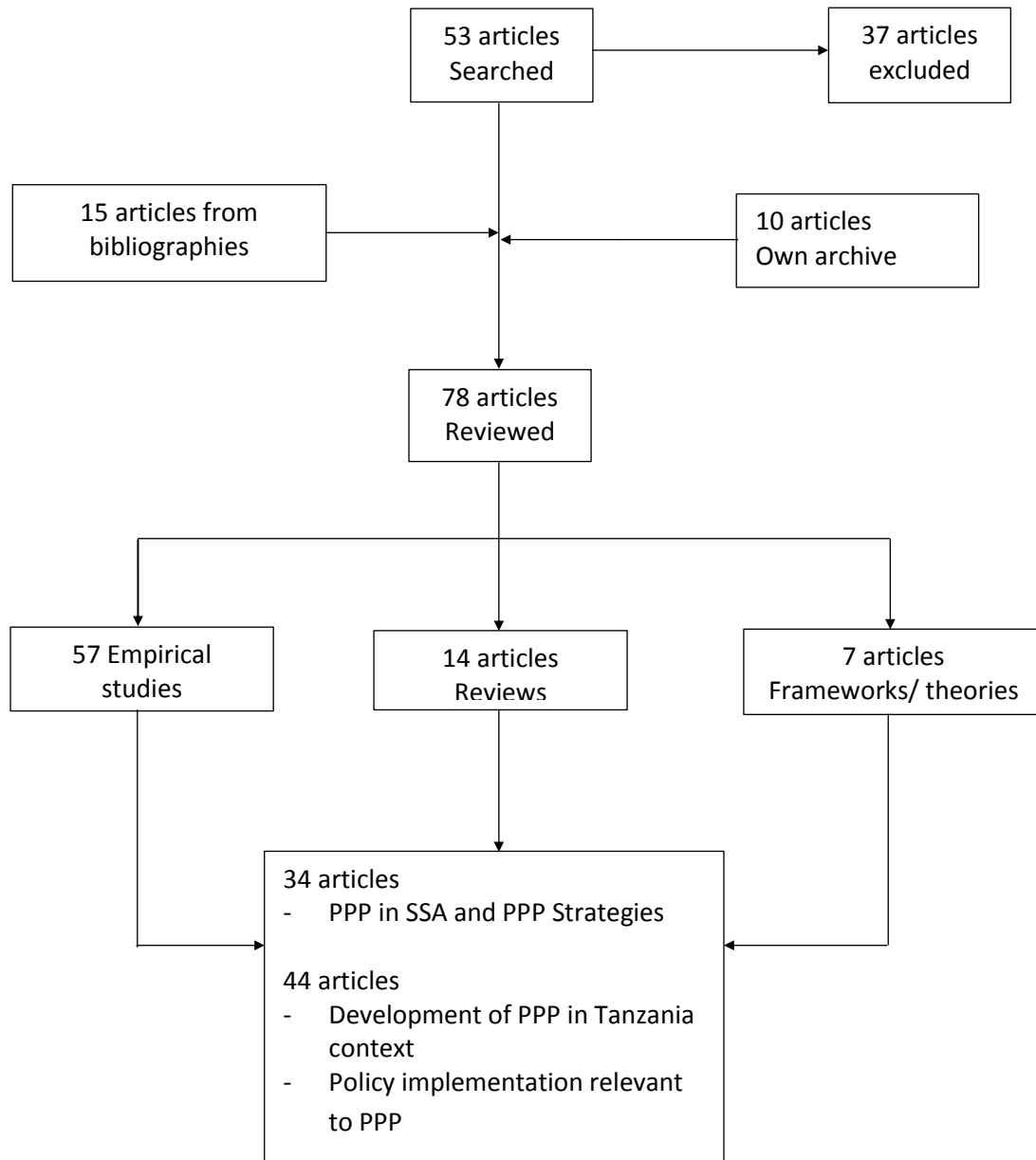
outcome, and how can PPP contribute to health systems strengthening. The findings are organised in three sections;

- PPP in the health sector in sub-Saharan Africa (SSA), which covers literature on what is PPP, and why PPP in SSA.
- Strategies for PPP, which covers literature on how PPP can improve health outcomes. The focus was on PPP mechanisms that have demonstrated to be effective in various settings in LMICs, and their role in reducing inequities, and improving health outcome.
- PPP in Tanzania context, which covers literature on historical context, and the PPP policy implementation.

The search for articles was done using Google Scholar as the primary search engine and database, and other articles were identified from the Pub-Med electronic database. Acts and policies were searched from official government websites such as parliament website, Ministry of Health and Social Welfare (MoHSW), Ministry of finance, and Prime Minister's Office-Regional Administration and Local Government (PMO-RALG).

The keywords that were used included, "public-private partnership", "private sector", "faith-based providers", "non-governmental organisations in the health sector", "community-based organisations", "engaging the private sector", "collaboration in the health sector", "Christian Health Associations", "health care reforms", "health reforms", "private for-profit", "private not-for-profit", "faith-inspired institutions", "contracting in health care", "contracting in the health sector", "self-sustained private providers", and "decentralization". More references were identified through the bibliographies of these

articles and from own archive (Figure I). Unpublished reports and grey literature were also considered in this review provided they met inclusive criteria.



**Figure I:** Articles that were included/ excluded for this review



For the first and second parts, relevant articles (Figure I) and reports from institutions such as the World Bank, WHO, and UNFPA were identified. Articles that fall into the following categories were excluded:

- Reforms focusing only in the public sector.
- How the community (users) could regulate the health care market.
- Market-based strategies that focused on job organisation rather than PPP.
- Comparison figures and trends about private and public sectors without focusing on PPP.
- PPP outside the health sector, though literature on performance-based contracting for supportive services such as procurement and supply was considered, (see Kleemann and Essig (2013) for example).

The historical context of PPP using Tanzania (one of LMICs) as a reference was considered by focusing on how the private sector emerged and how various challenges were addressed. This was done through review of relevant articles, and various acts and policies related to the private sectors from pre-independence to date. To enrich the understanding of implementing various PPP mechanisms, literature on policy analysis was reviewed, and available conceptual frameworks and theories analysed for their practicability in the PPP policy implementation.

### **Public-Private Partnership in the health sector in sub-Saharan Africa**

Sub-Saharan Africa countries require concerted efforts in developing and strengthening health systems as the region bears 26% of the global disease burden despite accounting for 13% of the world's population (World Bank Database 2014). Adding to limited public

resources facing most of SSA governments, pro-poor policies are either lacking or poorly formulated and implemented, contributing to underperforming health systems (Spreng et al. 2011). Un-pooled resources due to widely encountered out-of-pocket payments at the point of service delivery further limit efforts to improve efficiency and equity (see Marek et al. 2005).

The private sector contributes about 50% of the total health expenditures in SSA and serves all income levels (Marek et al. 2005; Spreng et al. 2011). The rich and the poor approximately equally utilize services from private sector as they would utilize services from public facilities (Castro-leal et al. 1999; Ghatak et al. 2008; Gilson et al. 1994). A significant growth in number of non-state actors in the private sector provides opportunities that can be tapped in order to strengthen health systems performance (Spreng et al. 2011). Engaging the private sector can increase coverage and improve the quality of health services, and reduce the harm that can be caused by unregulated private providers (Peters et al. 2004).

Private sector providers are a highly heterogeneous group, and can range from private not-for-profit (PNFP) providers such as faith-based organisations (FBOs), local and international non-governmental organisations (NGOs), community groups, private for-profit (PFP) providers, professional organisations to private practitioners operating alone, corporate private clinics and hospitals, traditional healers and informal drug vendors (see Gilson et al. 1994; Green et al. 2002; Peters et al. 2004; Spreng et al. 2011; Waters et al. 2003; World Bank 2004). The nature and scope of private providers differs from country to country, and the way in which their roles are incorporated to the national and sub-

national health systems also varies (Waters et al. 2003). In a country like South Africa, the private sector is mainly funded through insurance and operates in a relatively well regulated environment if compared to other SSA countries, however the private sector mainly serves the wealthy group (Spreng et al. 2011). This is contrary to what has been highlighted in other SSA countries like Tanzania, Uganda and Cameroon where the private sector and faith-based providers in particular, serve the poor and are located in remote areas. In these countries a mix performance of the private sector is observed contributed by somewhat ineffective coordinating mechanism (see Boulenger et al. 2009).

Faith-based providers have a long history in Africa that can be traced back to a time of missionary movements in early 20<sup>th</sup> century. Their purposes in health service delivery somewhat depended extensively on the external source of funding, and were partly missionary-driven linked to evangelism (Green et al. 2002). This type of institutional arrangements with FBOs still exist, though towards the end of 20<sup>th</sup> century the direct external funding declined, and efforts to collaborate with governments were intensified (Boulenger et al. 2009; Green et al. 2002). In many countries, FBOs and other voluntary organisations tend to compliment the public sector's efforts to reach the poor, and receive public subsidies from the state for personnel, supplies and maintenance of infrastructure (Osewe 2006). To date, FBOs are seen to share similar public health goals, and are overtly committed to serve the poor (Spreng et al. 2011), although as argued by Gilson et al. (1994) and Dejong (1991) it is questionable if they can operate to their expectations.

The experience with faith-based providers offers lessons that can be replicated with other non-state actors as most of SSA try to incorporate the private sector in social service delivery policies. However, there are emerging challenges as a result of health sector reforms that governments in SSA need to take into account as they actively promote PPP in the health sector (see Green et al. 2002). Firstly, a need for new collaboration with faith-based providers following widely implemented Sector-Wide Approach (SWAp)- a program that was initiated to promote coordinated sectoral planning and management of resources and move away from donor-led approaches, which are project-specific. Under SWAp external funds are channelled to a holding account commonly referred to as basket, and disbursement of consolidated funds is expected to be based on set priorities at the central and local levels, and cost-effective interventions that take into account local need (Spreng et al. 2011). Green et al. (2002) argue that this has restricted the direct link between faith-based providers and external funders since most funders have to realign with this requirement.

Secondly, decentralization offers a new opportunity to engage non-state actors in planning and policy dialogues at the local level (see Bossert 1998). It has been highlighted that local authorities are more familiar of who are the non-state actors in their areas, and could easily monitor their performance, and improve systems performance (see Agyepong 1999; Baker et al. 2002; Green et al. 2002; Spreng et al. 2011; Brinkerhoff and Bossert 2013).

Thirdly, Governments should appreciate that some international funders including bilateral and multilateral agencies still have interest to work with faith-based providers

more than public, based on the assumption of superior managerial practice and flexibility (Boulenger et al. 2009; Green et al. 2002). However, it has been argued by Bollini and Reich (1994), Dejong (1991) and Reich (2002) that these international agencies are driven by different goals and values. Fourthly, there are countries in SSA that have qualified for national debt relief, which provides an opportunity for those countries to channel more resources to the health sector, both private and public (Green et al. 2002; Spreng et al. 2011).

Lastly, as the private sector role in service delivery becomes widely recognised, emerging PFP providers could lead to competition with faith-based providers. Although from an economic perspective market-based features such as competition may improve efficiency towards broader welfare improvement (Petersen et al. 2006), faith-based providers may adjust in order to keep pace with the current emerging social and political complexity in service delivery (Boulenger and Criel 2012; Dieleman et al. 2012; Dimmock et al. 2012; Green et al. 2002; Olivier and Wodon 2012). Green et al. (2002) argue that NFP providers may divert from value-driven social services, which may further contribute to systems underperformance.

The experience with faith-based providers highlights the necessity of effective tools that would address evolving relational dynamics with the state, and further strengthen governance both at local and national levels.

## Strategies for Public-Private Partnership

As more countries undertake reforms to engage the private sector, concerted efforts headed for the formal collaboration would need to focus towards directing resources to underprivileged communities and increasing services utilization (Boulenger and Criel 2012; Castro-leal et al. 1999; Mackintosh and Tibandebage 2002; Marek et al. 2005; Patouillard et al. 2007; Peters et al. 2004; Spreng et al. 2011). Although there is a debate on the feasibility and impact of PPP on equity, available tools to engage the private sector offer promising results on increase in, quality of care, and services utilization by disadvantaged groups (see Patouillard et al. 2007; Peters et al. 2004). Peters et al. (2004) building on Waters et al. (2003) developed a model, which considered contracting, social marketing and franchising, financing, and collaboration as market-based strategies that can be used to influence the behaviour of private sector to promote public interest (Table I). Waters et al. (2003) referring to the child health services provision argue that market-based strategies can be applied in combination with administrative-based strategies to reach two goals, which are increasing coverage and improving the quality of care. These tools have been used to engage the private sector in health services provision in various SSA countries (see Hanson et al. 2008; Marek et al. 2005; Patouillard et al. 2007; Peters et al. 2004; Rosen 2000; Spreng et al. 2011). For example a voucher scheme is seen to be able to optimize skills of the private and public sectors as reflected in delivering emergency contraceptives in Zambia, and in Youth Health project in Kenya (Marek et al. 2005). However, challenges have been highlighted with the use of the voucher scheme in distributing insecticide-treated bed-net in Tanzania. These challenges include a nature of stakeholders, and how policy agenda are set at the national level (Njau et al. 2009).

Marek et al. (2005) claim that the behaviour of the private sector can be influenced using health insurance to make the sector more efficient. The health insurance, which can be mandatory pre-payment schemes, private voluntary schemes for those in the formal sector or a community health fund, 'encourages strategic purchasing of services on behalf of members through accrediting providers, negotiate payment terms, and monitor the quality and volume of services provided, thus provides incentives for providers to perform better.' Other output-based strategies highlighted by Marek et al. (2005) are: contracting provision of services (such as with faith-based providers in Tanzania, Chad, Cameroon, and Uganda – see Boulenger et al. (2009)), leasing equipment or facilities (as seen in South Africa where public facilities leases surplus bed space to private providers), concessions,<sup>3</sup> (South Africa is seen to have the most advanced hospital concessions among SSA countries), divestiture,<sup>4</sup> (uncommon in Africa, but a mix of divestiture and concessions has been highlighted in some SSA countries such as Mali and Cameroon) and franchising.

Spreng et al. (2011) suggested, there are five domains that collectively constitute the private sector engagement, which are: 'policy and dialogue, information exchange, regulation, financing, and public provision of services'. This is based on the models of Peters et al. (2004) and Waters et al. (2003), which stress a mix of administrative and market-based strategies, with policy and dialogue providing a foundation of the partnership, and support other elements.

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<sup>3</sup> 'Concessions require either management of public assets for a defined (usually long-term) period, or require new construction. The latter have several structures, the most common are BOT (Build-Operate-Transfer), BOO (Build-Own-Operate), and BOOT (Build- Own-Operate-Transfer)' (Marek et al. 2004).

<sup>4</sup> 'Divestiture is the selling of government assets to the private sector, forever' (Marek et al. 2004).

*In Table I below are the two categories of strategies that can be used to engage the private sector in health (Patouillard et al. 2007; Peters et al. 2004; Waters et al. 2003).*

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**Market-based:** approaches that can be used to influence the behaviour of healthcare providers to promote public interest

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- |                   |                                                                                                                                                                                                                                                        |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Contracting:      | Purchasing services from private providers, and applying benchmarks for the types of services provided, quality of care, amount of services provided or health outcomes.                                                                               |
| Financing:        | Using financial instruments such as grants, subsidies, tax incentives and in-kind support to influence behaviour of private providers.                                                                                                                 |
| Franchising:      | Contractual arrangement between individual member of networks of service providers and a franchise organisation.                                                                                                                                       |
| Social marketing: | Using commercial channels, techniques and communications approaches to market products with a public health benefit. It may include a combination of promotional activities, branding, labelling, pre-packaging and subsidy of public health products. |
| Voucher:          | A demand-side subsidy that the recipient can use as part or full-payment for a product or service from identified providers.                                                                                                                           |
| Collaborating:    | Developing organizational alliances among public and private sector actors to share resources and activities for a common purpose.                                                                                                                     |

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**Administrative-based:** approaches to ensure minimum standards and fair playing field among providers and service users

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- |                |                                                                                                         |
|----------------|---------------------------------------------------------------------------------------------------------|
| Regulating:    | Developing and applying the government laws and rules that place requirements on the private providers. |
| Training:      | Training private providers and using support such as job aids or patient materials.                     |
| Accreditation: | An oversight by an independent quality control evaluation body.                                         |



Perrot (2006) argues that the performance of health systems can be enhanced using formal contractual relations. Three categories are considered in this aspect, which are: firstly, contracts for devolution of public service such as, provision of public services by the private actor, leasing, and concession. Secondly, the contractual relationships based on the act of purchase between the fund-holder (purchaser) and health services provider, which focus on influencing the performance of the provider. And lastly, contractual relations based on cooperation such as collaboration between actors in strategic planning, joint management, and strategic alliances where resources from different actors are pulled together to complement each other to achieve a set target.

Based on this body of literature it can be argued that contractual relationships that incorporate both administrative- and market-based strategies, are appropriate for sustaining improvement in the health systems performance as they tend to move away from the traditional ways of input-based contracting (see Bennett et al. 1994; Kumaranayake et al. 2000; Ssengooba 2010). Likewise, it can be argued that service level agreements (SLAs) are an instrument in output-based contracting, and can be considered as an indicator for improved PPP. The establishment of SLAs is a supplier side solution, which has the potential to address inefficiencies by improving managerial innovation and discipline and provide for fair distribution of risk and reward (see Palmer 2000; Palmer and Mills 2005). For example in Malawi, the use of SLAs has revealed encouraging results, although a strong supporting system is required (see Chirwa et al. 2013).

From an economics perspective, SLAs are expected to drive performance improvement, however it can be argued from organisational sociology, anthropology, and psychology

perspectives that other factors such as human relations, leadership, governance, which are contextually influenced, interact with external incentives such as SLAs to lead to performance improvement (Mackintosh and Tibandebage 2002; Mills and Broomberg 1998; Ssengooba 2010). This further underscores the need for contractual relationships that focus on relational elements such as 'high level of trust, communication, cooperative problem-solving, interaction, and commitments—framed by a set of mutual goals' (see Kleemann and Essig 2013). Trust and transparency are seen as key for any healthy and successful partnership, however, they can easily change and limit the performance of the private sector in countries where there is 'real or perceived corruption, government instability, and unpredictable changes in taxation, legislation, regulatory enforcement, and subsidy allocations' (Spreng et al. 2011).

The WHO, in its 2000 World Health Report highlights how poorly structured, badly led, and inefficiently organised health systems may contribute to poor health outcomes. This WHO report further underscores the need for services contracting to those providers that have the best competence to deliver health services effectively, efficiently and of high quality. Devillé et al. (2005) argue in their Tanzania Annual Health Sector Review 2005 that, 'a pluralistic health system is a reality in low-income countries and will increasingly be so, and Tanzania will not be an exception with international trend'.

### **Public-Private Partnership in Tanzania**

In Tanzania like other sub-Saharan African's health systems, the private sector plays a significant role in service delivery, and for the past decade PPP has been widely promoted. In Tanzania's health system, non-state actors provide a wide range of services

ranging from preventive, curative to rehabilitative and in some areas are involved in pre-service training, pharmaceutical supply, and construction and maintenance of facilities (Itika et al. 2011; Musau et al. 2011; White et al. 2013). Similar to other SSA, the private sector in Tanzania is heterogeneous.

In Tanzania, PFP providers are more concentrated in urban areas (see Benson 2001; Makawia et al. 2010; Mtei et al. 2012; White et al. 2013), providing 19% of national services, largely curative services at the dispensary level (MoHSW 2009). Faith-based providers and other voluntary providers account for an estimated 15% of facility-based providers and are widely scattered including in hard to reach areas (Makawia et al. 2010). These figures do not include non-facility-based services such as pre-service training, health insurance, and commodity supplies, which are also provided by non-state actors in Tanzania. In districts with no public owned hospitals, faith-based hospitals have been accredited as Council Designated Hospitals (CDH) (White et al. 2013).

In Tanzania, the government remains the main facility-based provider, accounting for 65% of all facilities (Makawia et al. 2010) even though most of public facilities are faced with challenges such as shortage of supplies, and skilled and motivated staff (see Kwesigabo et al. 2012; Makawia et al. 2010; MoHSW 2008a; Rolfe et al. 2008). Although the consequences of this cannot be completely resolved by PPP, it would be partly addressed as the private sector not only provide additional service delivery points, but it is also a 'source of much-needed capital, competition among providers, management skills for operating complex systems like hospitals, and innovation and flexibility in health care delivery' (Spreng et al. 2011). Gilson et al. (1994) argue that private providers are

expected to have superior technical and managerial skills, as they operate outside government bureaucracy, however, this can be achieved with a strong coordination between non-state actors, and between the private sector and Government in order to avoid substandard work (Dejong 1991; Gilson et al. 1994).

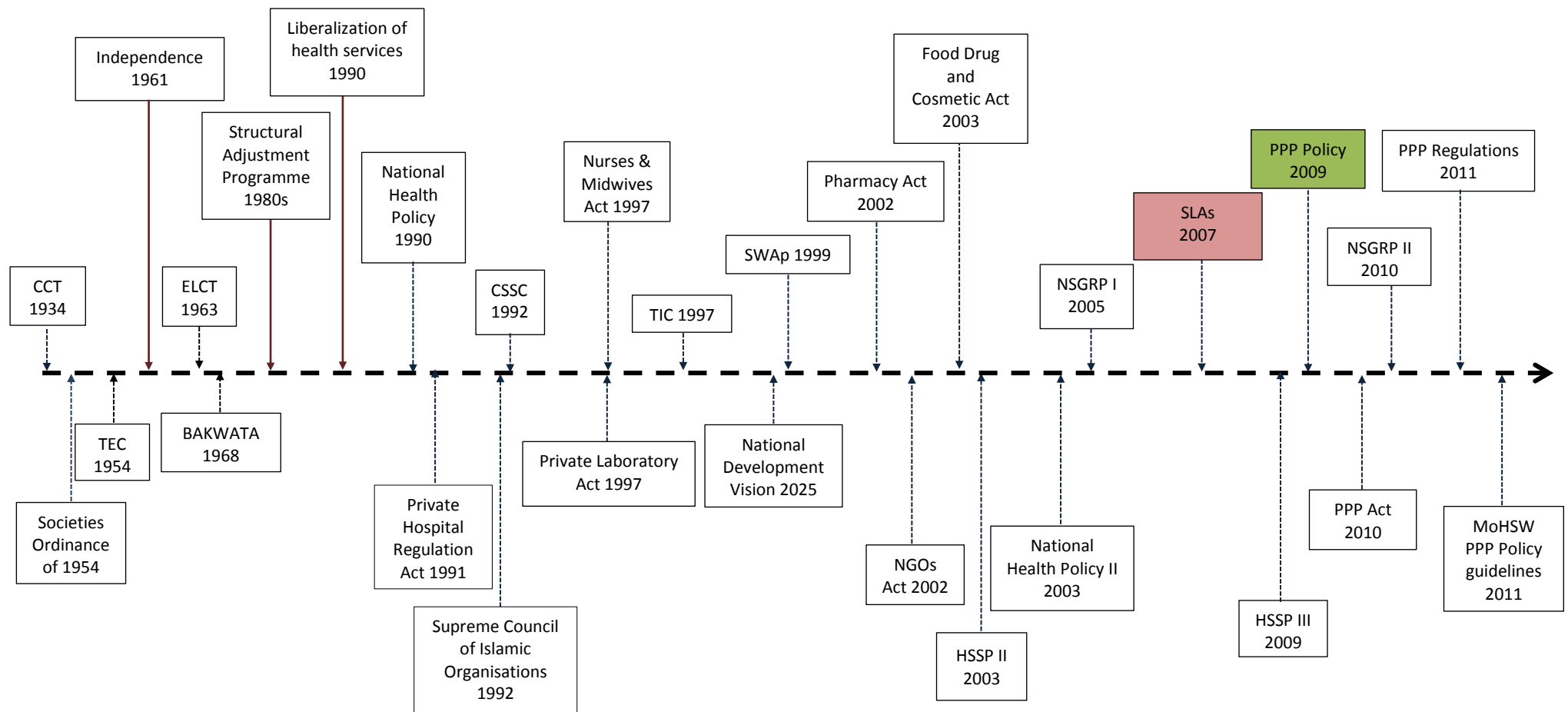
### **Public-Private Partnership in historical context in Tanzania**

The history of private providers in the health sector in Tanzania dates back to colonial administration, a time when faith-based providers in particular were well established before independence in 1961 (Figure II). Two apex bodies, Protestants Christian Council of Tanzania (CCT) founded in 1934, and Catholic Tanzania Episcopal Conference (TEC) founded in 1954 coordinated the work of FBOs in social services provision among individual denomination and their engagement with the colonial government (Leurs et al. 2011). Muslims Council of Tanzania (BAKWATA) was another religious apex body formed in late 1960s. Changes in the national social and economic policies to socialist ideology in late 1960s and in 1970s affected the scope of social services provided by non-state actors, especially the FBOs (Boulenger et al. 2009; Leurs et al. 2011). Although these changes in development philosophy created tension among non-state actors as a result of reinforcing the control of the state, FBOs re-oriented their social missions to align with national development policies (Jennings and Clarke 2008; Leurs et al. 2011). The Relief and Social Services division, and Caritas were two specialized departments formed by CCT in 1963 and TEC in 1971 respectively, to 'define the relationship between the state and churches, coordinating development activities and seek external funds' (Leurs et al. 2011). The state control included limiting the role of private providers, and in some areas, facilities were nationalized (see Leurs et al. 2011; Munishi 1997), for example Bugando

Catholic Hospital, and Lutheran Kilimanjaro Christian Medical Centre become government referral hospitals (Boulenger et al. 2009).

Faith-based providers that remained prominent after independence were categorized as PNFP (Leurs et al. 2011). Some faith-based facilities in districts become Designated District Hospitals (DDH) in early 1970, as the government tried to address the shortage of public facilities (see Boulenger et al. 2009). Although these facilities received subsidies from the government, it can be argued that the collaboration was more relational, as the contract model that existed was input-based and in some cases was not signed immediately (see Boulenger and Criel 2012). The PFP providers were banned in late 1970s, after the private hospitals (regulation) act 1977, came into operation.

The fall of socialism, and the national economic crisis due to, fall of East African Community in 1977, high oil price, and the Uganda war are claimed to have overstretched the capability of the government in attaining social goals (Munishi et al. 1995). The decline in external assistance in late 1970s due to the government's economic policies that were not supported by bilateral and multilateral agencies further exacerbated the situation (Leurs et al. 2011). This partly did not affect the quality of care provided by existing NGOs and FBOs as they continued to mobilize external funds for development projects including health care (Sivalon 1995). It can be argued that this significantly contributed to the perceived quality of health care provided by non-state actors in Tanzania. Olivier et al. (2012) in their study on faith-based health care provision in Ghana argue that 'the reasons that lead patients to choose faith-inspired providers are not



**Figure II: Public-Private Partnerships in Tanzania – the evolution of coordination, legal and institutional framework (Author).**

related directly to religion, but rather to the quality of the services provided, including values of dignity and respect for patients that the facilities exhibit’.

Severe economic constraints in 1980s led to the liberalization of economic policies towards the market-driven economy (see Due 1993; Munishi et al. 1995; Walt and Gilson 1994). Like other LMICs, Tanzania introduced the structural adjustment program, which led to liberalization of health services to promote the development of the private sector (Harrington 2004). Non-state actors that were banned in 1977 were re-introduced following the amendment of the private hospitals (regulation) act 1977, in 1991. The involvement of the non-state actors in the provision of health services also featured in the first National Health Policy in 1990, however it can be argued that the focus was more on cooperation principles in social service delivery, than mechanisms that would improve health outcomes through partnership with the private sector.

The Christian Social Services Commission (CSSC) was formed in 1992 by CCT and TEC to coordinate and support the provision of education and health services by churches. The CSSC was also involved in negotiating policy and their financial relationship with the government (see Dimmock et al. 2012; Sivalon 1995), as the government continued to rely more on services offered by FBOs (Leurs et al. 2011). In 1994, the Association of Private Health Facilities in Tanzania (APHFT) was formed, mainly representing the self-sustaining providers in policy and dialogue with the government (APHFTA 2011). However, the model contract to define the relationship with private providers was not changed (Boulenger et al. 2009), reflecting the traditional focus on input-based practices.

Following liberalization of social services in Tanzania the number of non-state actors, mainly local NGOs, increased substantially (see Kiondo and Mtatifikolo 1999). It can be argued that this contributed to a fragmented health system as several NGOs in the health sector were influenced by international donor agenda with specific project interest and not being responsive to local need (see Dejong 1991; Gilson et al. 1994; Green et al. 2002). Some non-state actor providers increasingly depended on user fees. This has been argued by Gilson et al. (1994) could lead to the 'vicious cycle of falling resources, rising prices, lower quality, and lower utilization', which has an impact on equity and quality of care. Some NGOs started operating as PFP to compete with other PFP providers in the market (see Gilson et al. 1994; Marek et al. 2005). It can be argued that this further contributed to limited health gains despite efforts to collaborate with the private sectors.

In an effort to regulate the private sector, several Acts came into operation in the late 1990s and early 2000s. This included the Private Health Laboratories Regulation Act (1997), the Nurses and Midwives Registration Act (1997), the Pharmacy Act (2002), Tanzania Food, Drugs and Cosmetics Act (2003), and the Non-Governmental Organizations Act (2002). Although such administrative strategies were required, they created a type of a relationship, which was seen as 'a regulator and regulated' relationship, and 'a one-time partnership' (see Marek et al. 2005; UNFPA 2008). Limited engagement in policy and dialogue was noted. This situation was further contributed by the decentralization that was seen to create dysfunctional communication channels between centrally coordinated regulatory bodies and the sub-national health systems (see Boulenger and Criel 2012).



The Tanzania Investment Act (1997) was another initiative aimed to attract non-state actors across all sectors to participate in social and economy development. This Act provided for more favourable conditions for investors as their potential became increasingly recognised. This is further seen in the National Development Vision 2025, and the SWAp initiative, which were both adopted in 1999 (PO 1999; MoHSW 2007). The second National Health Policy (2003) building on the emerging challenges in the private health sector, emphasized PPP as the strategy to achieve the policy goal of improved access, quality, and affordable care (MoHSW 2003). The decentralization structure is stated in the policy paper on local government reform (PMO-RALG 1998), and the role of the MoHSW and Local authorities are outlined in the second National Health Policy (MoHSW 2003) as well. Such efforts are also seen in the Health Sector Strategic Plan II (2003 - 2008) (MoHSW 2009). Furthermore, efforts to engage the private sector are seen in the first National Strategy for Growth and Reduction of Poverty (NSGRP I) 2005, which stressed that, 'factors that hinder the active private sector participation in the economy will be addressed through friendly trade and investment policies' (VPO 2005).

Following decentralization, the initial model of contract with DDH was changed in 2005 and a new contract with inputs from private actors was introduced. The name DDH was changed to Council Designated Hospital (CDH) (Boulenger et al. 2009). The focus of these reforms was to engage local councils with local private actors. Although there was explicit government commitment to engage the private health sectors since in early 1990s, it can be argued that more efforts were input-based focusing on accreditation, licencing, subsidies, and in-kind support. This was revealed in the private sector assessment in 2005, as Devillé et al. (2005) recommendations focused more on output-based strategies such

as contracts management that included SLAs, dialogue, resource sharing, and quality assurance.

SLAs were introduced in 2007 as a new operational contract, aiming at setting clearly stated performance indicators when engaging the private actors (Boulenger et al. 2009; MoHSW 2009). The Health Sector Strategic Plan III (2009 - 2015) further emphasised the need for formal contracts between District councils and non-state actors. SLAs were expected to provide mutual benefits to both entities, and facilitate access to public resources by private providers (MoHSW 2009). This is also stated in the SWAp Code of conduct (MoHSW 2007). SLAs offer an opportunity for regulated collaborations and are seen as an important indicator of improved PPP (MoHSW 2009).

Even though partnership with the private sector existed for several years it can be argued that the lack of comprehensive policy, legal and institutional framework for PPPs somewhat limited health gains. Kruger et al. (2011) and Rolfe et al. (2008) for example argue that limited resources and challenging environment where non-state actors operate might contribute to inadequate or low quality of service delivery. These gaps are addressed in the national PPP policy that was adopted in 2009, which lays the foundation for performance-based contracting. This policy highlights how resources, risk and rewards can be appropriately allocated by building on the expertise of each partner (PMO 2009). The national PPP policy was followed by the PPP Act (2010), which provides for institutional framework for implementation of public-private agreements. The national PPP Regulations Act (2011) further consolidates the operational guidelines and

procedures to ensure that PPPs are technically, financially, economically and socially viable.

The MoHSW in conjunction with the PPP-Technical Working Group under the Ministry further drafted the Health Sector and Social Welfare PPP Policy Guidelines (MoHSW 2011), which are sector specific and aligned to the national PPP Policy, PPP Act (2010), and the PPP Regulations Act (2011). Although the health sector specific PPP Guidelines' document is detailed, and tries to address inefficiency in service delivery, and quality improvement, it lacks clarity on how to address inequities and improve accountability. It focuses more on external factors such as fair distribution of risks and rewards between the two entities, with somewhat limited relational elements and well-defined health outcomes. Although such contractual arrangements provide for more flexibility and cooperation in countries with potential institutional and market failure, as argued by Palmer (2000) 'closer scrutiny of the dynamics of contractual relationships in such settings is required'. This reflects the need for effective coordination in implementing the national PPP policy in the health sector in order to improve the health system performance at the local level.

### **Public-Private Partnership Policy implementation in Tanzania**

The PPP policy is seen to be able to achieve the following: firstly, improve mechanisms of resource sharing at the district level for situations like referrals and the use of medical technology. Secondly, extend the reach of health services to the most underserved communities given resource constraints facing the Government. Thirdly, PPP is seen to be

able to address the rural and peri-urban local need, for pharmaceuticals and medical supplies. And lastly, partnership is seen to be able to improve health system responsiveness to local need (see Brinkerhoff 2004; Budge-Reid et al. 2012; Centre for Pharmaceutical Management 2008; Conteh and Hanson 2003; Gilson 2003; Itika et al. 2011; Kamuzora and Gilson 2007; Makawia et al. 2010; Mtei et al. 2012; Musau et al. 2011; Mutale et al. 2013; Reich 1995; Rosen 2000; Savedoff and Gottret 2008; White et al. 2013; World Bank 2011).

Implementation of PPP policy in the health sector can be well understood using conceptual frameworks available in literature. Walt and Gilson (1994) argue that policy implementation is non-linear and a 'policy analysis triangle', which consists of the policy content, process, and context, with actors at the centre, can help to think more systematically. This policy analysis framework takes into account interrelations among complex social, political, and economic factors. This is contrary to other schools of thought that consider the policy implementation as a top-down process of change controlled by central actors (see Meessen et al. 2011). Kamuzora and Gilson (2007) on their article that explored factors that influence the implementation of the Community Health Fund (CHF) in Tanzania, concluded that during the implementation, policies are re-shaped and re-interpreted in unexpected ways by front-line bureaucrats thus directly affecting policy outcomes. According to Lipsky (1980), policy implementers tend to shape how a policy is translated into practice based on how they understand the policy, as well as its relevance with their working routines, values and interests. Likewise, Buse et al. (2009); Birungi et al. (2001); Schneider et al. (2006) and Walker and Gilson (2004) argue in the same line.

Building on Walt and Gilson (1994) framework, it can be argued that the decision-space framework by Bossert (1998) and accountability linkage framework by Brinkerhoff (2004) can be used to explore actors interactions and the process of the PPP policy implementation. Bossert (1998) presented a decision-space approach that consider the decentralization as an on-going process, and argues that essential features for a nation to achieve health reforms' broader objectives are:

‘incentives that central government can offer to local decision-makers to encourage them to achieve health objectives, the local government characteristics that influence decision making and implementation at the local level, and whether local officials innovate by making choices that are different from those directed by central authorities’ (Bossert 1998).

Brinkerhoff (2004) highlights the important role of dialogues that should lead to improved service delivery and contribute to sound policymaking. Actors' even power distribution as related to the capacity to demand and supply information and exercise oversight and sanctions, and accountability linkages are also considered to be able to bridge performance gaps (Brinkerhoff 2004).

Drawing on the decision-space and accountability linkage frameworks it can be argued that, the decentralized system underscores the importance of effective PPP mechanisms that would impact on efficiency, equity and quality of services delivered (see Bossert 1998; Brinkerhoff 2004). The decentralized system in Tanzania provides autonomy for each district to develop and manage its own Comprehensive Council Health Plan (CCHP),

which has to be in line with the national priorities. This provides a decision-space for a range of choices and innovation that can be made to improve performance by working with non-state actors at a local level (see Baker et al. 2002; Bossert 1998).

The national PPP unit, and PPP-Technical Working Group established under the MoHSW that are spearheading the implementation of the PPP policy, and provide technical coordination at the national level for effective policy implementation (Africa Health 2012), may partly address gaps indicated to underlie the slow progress in improving overall health system's performance (see Buse et al. 2009; Kamuzora and Gilson 2007; Musau et al. 2011; White et al. 2013). However, it can be argued that given the complex nature of the private sector, contextual factors such as actors' relations, cultural patterns, political trend, local accountability structures, and local organisational and administrative systems would also play a key role in the PPP policy implementation (see Maluka et al. 2011; Reich 1995; Roberts et al. 2008; Walt and Gilson 1994).

The PPP Policy implementation in the health sector at the district level can be well demonstrated using partnership for improved RCHS provision, as it can be argued that RCHS provide a real life context for PPP. RCHS involve multiple expected implementing partners, some RCHS are expected to be provided by private facility-based providers free of charge, and may be provided without consultation in the retail sector (Conteh and Hanson 2003; Rosen 2000; White et al. 2013). Moreover, RCHS are essential public health services, and the MoHSW priorities (MoHSW 2008b; MoHSW 2009).

While Peters et al. (2004) argue that 'qualitative case studies are needed to elucidate how particular interventions (PPP strategies) can actually be implemented, what actors and processes are affected, and what type of consequences they have reaped', Olivier and Haddad (2012) suggest that studies at the district level would be useful to understand how collaborative engagement operates differently from the national-level engagement. Thus, a study that focuses on the PPP Policy implementation at a district level using a qualitative lens would provide a rich understanding of a complex reality (see Crowe et al. 2011). Peters et al. (2004) further argue that 'such analysis can lead to important conclusions on how to deal with important contextual factors, such as the nature of the market, political processes and stakeholder concerns'.

## **Conclusion**

Although SSA countries are increasingly recognising the role of the private sector, there is still no agreement on the effective mechanisms to engage the private sector that would address equity and improve health outcomes. Market-based strategies, when combined with administrative strategies are likely to lead to healthy partnerships that can improve system performance, however rigorous research are still required to establish the impact of PPP mechanisms on equity.

PPP will continue to be influenced by the strength of the health care market and governance within the country, thus incorporating contextual elements when designing strategies to engage non-state actors remains as a foundation for successful PPP.

Nevertheless, principles of output-based contracting, and relational elements remain as a cornerstone in achieving social goals.

Faith-based providers, who have existed for several decades, need to adjust in order to address emerging complex range of factors that influence the health care market in LMICs. Sharing experience and best practice with local governments including what did not work, when considering scaling-up of various initiatives is likely to contribute to improved systems performance. Policy analysis tools provide a rich understanding of PPP mechanisms implementation, and can further shape and re-shape the implementation in an effort to strengthening the national and sub-national health systems. Moreover, country's historical context must be carefully thought-off when designing mechanisms to engage the private sector.

PPP initiatives have focused more on engaging the private sector at the national level – however, it would be of interest to compare and contrast levels of engagement at the national and sub-national levels. For example in Tanzania there are a large number of PPP related policy documents and reports, but fewer empirical studies that show how these policy documents and reports are implemented. In the next section that follows findings of a case study that explored PPP at a district level in Tanzania are presented and discussed.



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# **PART C: JOURNAL ARTICLE MANUSCRIPT**

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**Journal Targeted: Health Policy and Planning**

**Health System's Barriers Hindering Implementation of Public-Private Partnership at the  
District Level: A Case Study of Partnership for Improved Reproductive and Child Health  
Services Provision in Tanzania**

**DENICE KAMUGUMYA<sup>1</sup>**

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<sup>1</sup> Instructions for authors in Appendix IX, authors' contribution and information are also excluded. For the purpose of this thesis, the student is the sole and first author of the work.



## Key messages

- The effectiveness of public-private partnership's (PPP's) contribution to health goals at the sub-national level depends on the local government capacity to address actors' relational elements dynamics and the ability of governing bodies with authentic private sector representation to oversee the district strategic planning.
- Provision of public services by private providers without service level agreements (SLAs) may impede national efforts to promote the private sector to improve health system performance. Non-state providers may divert from public goal, and pursue their own interests. Memoranda of Understandings that are considered by local government officials instead of SLAs provide for more flexibility during implementation, but require effective coordination, including strong accountability linkages to be effective, which are often lacking at a district level.
- New social contracts that would bring all non-state actors to the centre of the district health system are essential to foster PPP and strengthen the district health system in return. These types of social arrangements should shift the focus from individual service's entry to health care market to systems' level dynamics.

## Abstract

Public-private partnership (PPP) has been suggested as a tool, to assist governments in lower to middle income countries fulfil their responsibilities in the efficient delivery of health services. In Tanzania, although the idea of PPP has existed for many years in the

health sector, there has been limited coordination, especially at a district level – which has contributed to limited health gains or systems strengthening obviously seen as a result of PPP. This case study, which draws on the decision-space framework, was conducted in the Bagamoyo district of Tanzania, and employed in-depth interviews, document reviews, and observations methods. The study findings reveal several forms of informal partnerships between the local government and non-state actors. The lack of service level agreements (SLAs) for facilities that receive subsidies from the government is argued to contribute to inappropriate distribution of risk and reward leading to moral hazards. Furthermore, findings highlight weak capacity of governing bodies to exercise oversights and sanctions, which is exacerbated by weak accountability linkages and power differences. Moreover, restricted flexibility in spending is seen to deter prompt actions to address evolving population needs, given limited local fiscal space. It is concluded that effective PPP policy implementation at a local level depends on the capacity of local government officials to make choices that would embrace relational elements dynamics in strategic plans. Disempowered Council Health Services Board, in relation to engaging non-state actors, is shown to impede PPP initiatives. There is a need for new social contracts that would bring all non-state actors to the centre of the district health system, and strengthen the system in return.

**Key words:** *health system, partnership, collaboration, engagement, private for-profit, self-sustaining, faith-based providers, not-for-profit providers, moral hazards, service level agreement, memorandum of understanding, non-state actors*

## Introduction

Through its national public-private partnership (PPP) policy the Government of Tanzania recognises the important role of PPP in achieving social goals (Africa Health 2012; MoHSW 2011; MoHSW 2009; White et al. 2013). This policy was adopted in 2009, and later followed by the PPP Act in 2010. It stresses a need for the proper analysis of supporting structures (political, economic and social structures) to ensure there is appropriate distribution of risks and rewards between collaborating parties (PMO 2009). The Health Sector Strategic Plan III (2009-2015), further highlights the need to address gaps in health care delivery by avoiding overlaps and unnecessary competitions with more emphasis on service level agreements (SLAs) (MoHSW 2009). SLAs are a supplier side solution that provide opportunity for private providers to access public funding (MoHSW 2009) and in return improve equity, efficiency and quality of services delivered (see Boulenger and Criel 2012; Chirwa et al. 2013; White et al. 2013).

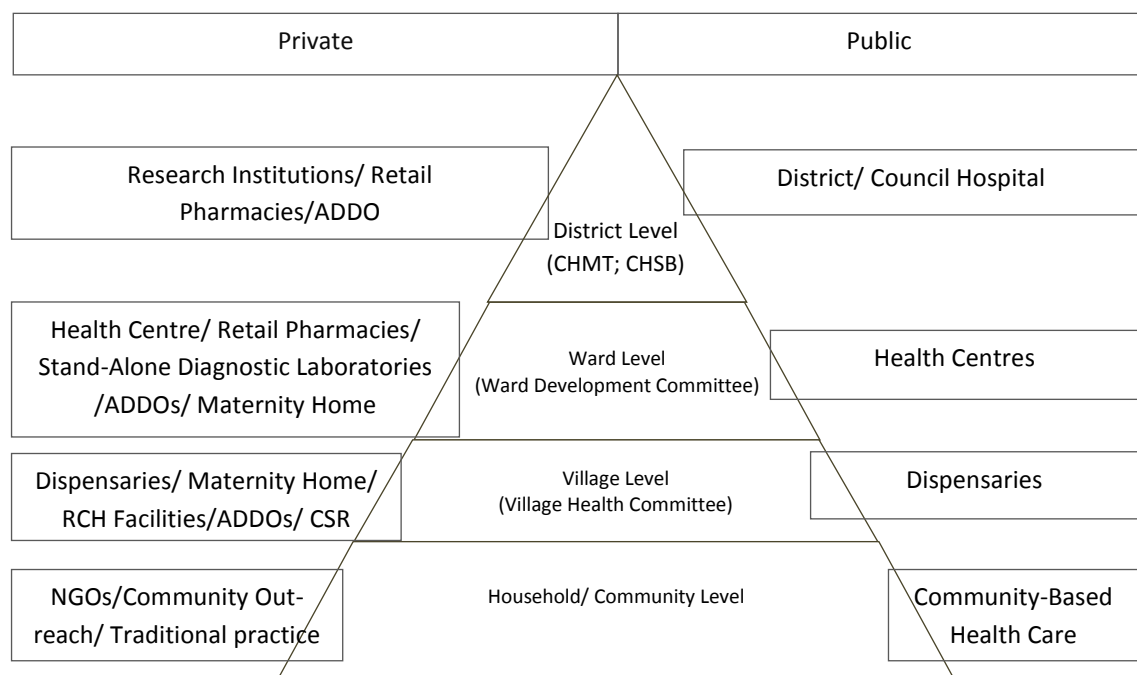
In Tanzania, at a district level, the private sector is highly heterogeneous, and consists of private not-for-profit (PNFP) providers such as faith-based providers and voluntary services, private for-profit (PFP) providers, local and international Non-Governmental Organizations (NGOs), private practitioners operating alone, corporate private clinics and hospitals, traditional practice, informal and formal drug vendors, pharmacies, and stand-alone diagnostic laboratories (MoHSW 2011). Facility-based PFP providers are more concentrated in urban and peri-urban areas (see Benson 2001; Makawia et al. 2010; Mtei et al. 2012). PNFP providers, drug vendors, traditional practice and sporadically stand-

alone diagnostic laboratories tend to operate in hard to reach remote areas (see Centre for Pharmaceutical Management 2008; White et al. 2013; Itika et al. 2011).

Disaggregated data by the type of non-state actors indicate that the rich and poor approximately equally utilize services from the private sector (see Makawia et al. 2010). A significant amount of out-of-pocket payments are happening in the private sector. Country-wide 32% of the total health expenditure comes from out-of-pocket payments (Mtei et al. 2012), with 11.2% and 19.9% of the total health expenditure made at PFP and PNFP facilities respectively (White et al. 2013). The emerging private providers, and faith-based providers who have existed for a long time, provide opportunity that can be tapped in order to address the disproportional distribution of health services and inefficiencies in service delivery (see Spreng et al. 2011; White et al. 2013). Engaging the private sector should also reduce the harm that may be caused by unregulated providers (see Peters et al. 2004).

Although the idea of PPP has existed for several years, lack of effective coordination mechanisms at the sub-national level can be argued to have contributed to limited health gains. It is further argued that the slow progress in improving overall health system's performance is ascribed to limited capacity to coordinate resources, identify effective technical strategy, and scale-up effective interventions, and inadequate managerial practices (see Buse et al. 2009; Kamuzora and Gilson 2007; Musau et al. 2011). Itika et al. (2011) and White et al. (2013) claim that there is limited understanding and recognition of the PPP concept at the district level.

Furthermore, White et al. (2013) have highlighted missed opportunities to introduce SLAs in areas where some population groups are underserved. For example, in other locations private providers are the only facilities, which may be operating in a given geographical area, but those who are entitled for exemptions, fee exemptions do not apply. This is also seen when public facilities run out-of-stock for essential medicines, which happens quite often (Musau et al. 2011; Mtei et al. 2012; Makawia et al. 2010). This indicates the need for effective mechanisms to provide services based on need, and not ability to pay, by working together with all types of providers.



**Figure 1:** The District Governing Structure and Non-State Actors in the Health Sector.

*Modified by the author from White et al. (2013)*

Widely promoted reforms in retail services in the last decade are seen to contribute to widely dispersed Accredited Drug Dispensing Outlets (ADDOs), also known as essential drug shops. Although these reforms were initiated to address the rural and peri-urban local need for pharmaceutical and medical supplies, they seem to bring in new relational dynamics that require effective coordination mechanisms (see Centre for Pharmaceutical Management 2008). The same trend is seen with stand-alone private diagnostic laboratories (White et al. 2013). Gaps have been highlighted with these reforms, for example lack of quality assurance leading to poor quality of services, and uncontrolled price of commodities, which exacerbates inequity (see Makawia et al. 2010; Musau et al. 2011; White et al. 2013). Such reforms could lead to collaboration, competition, and conflicts among involved entities in political arena, which may further contribute to system underperformance (see Reich 1995).

The revised District Health Management Information System (DHMIS) provides an opportunity to improve system responsiveness by gathering information from all types of providers and making evidence-based decisions that can inform strategic planning sessions (see Mutale et al. 2013). However, this would depend on how non-state actors are engaged at the district level, and relationships established with shared values (see Gilson 2003). Some limitations have been highlighted such as accountability structures, and distrust, which if not addressed could limit efforts to heighten responsiveness (see Itika et al. 2011; Musau et al. 2011; White et al. 2013).

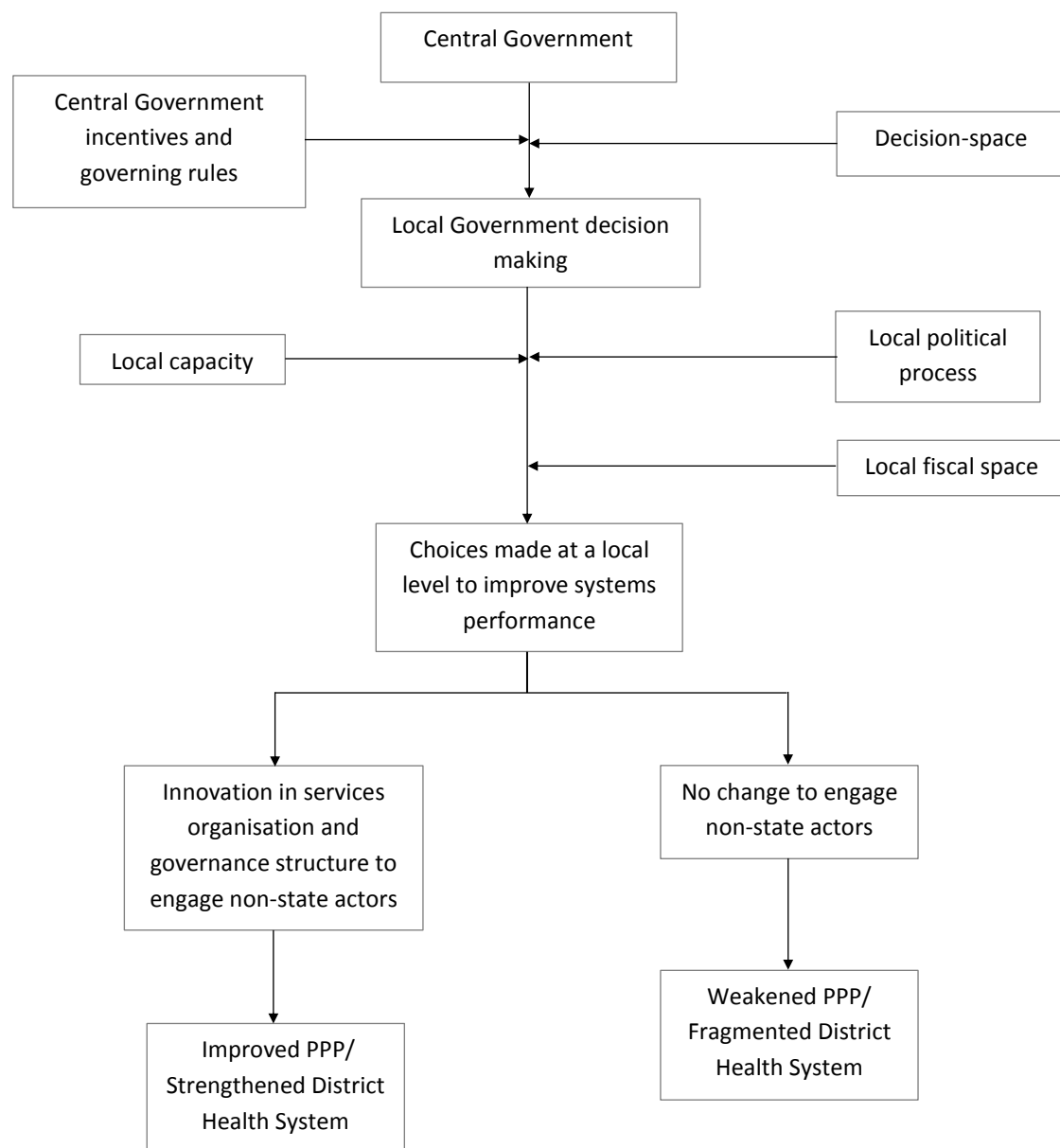
There is a strong PPP technical coordination at the national level in Tanzania as demonstrated by the existence of the PPP Unit under the Ministry of Health and Social Welfare (MoHSW), PPP-Technical Working Group, and various PPP dialogues (Africa Health 2012; White et al. 2013). At the district level however, this would depend on the district governance structure and the presence of appropriate competencies to effect change. This includes the ability to facilitate inclusive policy dialogue and strategic plans at the local level that would improve the accountability and decision-making processes in order to achieve health goals (see Brinkerhoff and Bossert 2013; Bossert 1998). This study using a qualitative lens is intended to provide a rich understanding of a complex reality of barriers that hinder PPP at a local level.

## **Methods**

A case study approach was employed to gain a broader understanding of multiple interconnected factors underpinning PPP (see Russell 2005; Crowe et al. 2011). Bagamoyo district, the district of focus in this study, in the Eastern zone of Tanzania is situated 75 km North of Dar-es-Salaam, the main business and trading city in the country. This district has an urban-rural population presenting appropriate district for this case study. Bagamoyo district was selected for the study because it was easily accessible to the researcher, matching the time and financial limitations.

Bagamoyo district has one hospital, which is publicly owned, while private facilities operate at levels of health centres and dispensaries (MoHSW 2014). This presents a difference with other districts in Tanzania, which often have faith-based appointed

district hospitals known as Council Designated Hospitals. However, with the decentralized system, the governance structure is the same across all districts in Tanzania (Figure I). The policy leadership and stewardship role is provided by the MoHSW and operational role is undertaken by local governments (MoHSW 2009).



**Figure II:** Study framework (author) with inputs from the decision-space framework by Bossert (1998)



This study draws on the decision-space framework by Bossert (1998) (Figure II), which considers a decision-space as the amount of choices (degree of autonomy) transferred to local officials in a decentralized system. This study focused on the decision-space on services organisation more broadly, and on contracting private providers in particular. The characteristics of local actors in PPP, and the type of choices local official-as agents can make to improve system performance through PPP were also explored. The local fiscal space is considered, but how finances and other incentives are allocated from the central government-the principal, and PPP central governing rules as defined by law were not within the scope of this study. Stakeholder analysis was conducted to understand the power distribution, and interest of local actors to engage non-state actors.

Since PPP involves multiple implementing partners, provision of Reproductive and Child Health Services (RCHS) was used as a context in order to uncover the socio-political complexity in the PPP policy implementation. RCHS includes services such as family planning, immunization, gender-based violence, male involvement, PMTCT, youth-friendly initiatives, prevention and management of childhood illnesses, antenatal care, and delivery and post-natal care (MoHSW 2008). Based on MoHSW guidelines RCHS are considered as essential services, some services are required to be provided by private providers free of charge, and in the retail sector there is a fee and may be provided without doctor's consultation (MoHSW 2008; White et al. 2013). The focus on RCHS at a district level was expected to provide the complexity expected in PPP, and simultaneously make this study easily manageable.

The sample for this study was purposefully selected from a stakeholder map (see appendix VII) that was established after a stakeholder analysis. Data collection employed in-depth interviews, observations of participants (including interaction with service users), and document reviews methods. The saturation point was reached with 30 interviews in total. A social network sketch (see appendix VI) was used for each interview as a tool to facilitate identification of actors' linkages or interactions. To ascertain whether PPP mechanisms that do exist are successful (effective) the focus was on how these mechanisms have contributed to improved, equity in accessing care (access based on need, not ability to pay), efficiency (improved availability of essential medicines) and quality of care (appropriate skill mix). Consent was obtained for interviews (with voice recording in most cases). All scripts were coded, and no any personal identifiers were used. Field notes were used to collect observation data. This study was approved by the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee, and the Health Research Ethics Review Committee in Tanzania under the National Institute for Medical Research.

Recorded interviews were transcribed verbatim in Swahili and then translated to English. This was then followed by coding, organising and reorganising data and emerging themes manually. The initial analysis guided further data collection in an iterative process. Data from each category of non-state actors (Table I) were analysed and triangulated separately. Themes were generated for each category, and then interrelated across categories to identify emerging patterns. Reflexivity was considered to manage

researcher bias. Respondent validation was instituted to ensure the meaning is not distorted.

## **Findings**

In this case study a number of important themes emerged that include factors that hinder and support PPP. In this article, we report mainly on factors that hinder the implementation of the PPP policy in Bagamoyo district in Tanzania.

### **Public-private partnership and governing bodies: Challenges and limitations**

There are health governing organs at all three levels in the district. The District Council Team, Council Social Services Committee, Council Health Services Board (CHSB) and Council Health Management Team (CHMT) at the district level, the Ward Development Committee, and Ward Health Committee at the ward level, and the Village Health Committee, which was also referred by community members as Facility Health Committee for a respective public dispensary in the village.

According to available guidelines, at the district level, the higher governing body with the private sector representation is the CHSB only. However, in Bagamoyo District, the CHSB is not strong as the private sector representation lacks authenticity. This is seen from responses from facility managers and owners of ADDO, pharmacies and stand-alone diagnostic laboratories. As one participant said:

‘I have heard of the CHSB, but I don’t know what it is usually discussed. We don’t have a representative. We (private providers) are considering forming an

association and then appoint leaders, who would then be our representatives.

But we have not yet managed to form that association' (Facility Manager – Bagamoyo 2014).

**Table I:** PPP actors' accountability matrix, adapted from Brinkerhoff (2004)

Cases	Demand Information /Impose Sanction					
	DMO Team	Private Laboratory Board	Pharmacy Council	Funder/ Donors	Community - based committees	Own Board/ Committee
Not-For profit providers	⇒ ↓	⇒ ↓			→ ↓	➡ ↓
For Profit facility-based providers	⇒ ↓	→ ↓			→ ↓	
Stand-alone laboratories	→ ↓	→ ↓			→ ↓	
Parastatal facility-based	➡ ↓				⇒ ↓	➡ ↓
Corporate Social Responsibility	➡ ↓	→ ↓			⇒ ↓	➡ ↓
Pharmacies	→ ↓		⇒ ↓			
ADDOS	→ ↓		→ ↓		⇒ ↓	
Voluntary Services and NGOs	⇒ ↓			➡ ↓	➡ ↓	
Research Institute	➡ ↓			➡ ↓	→ ↓	
Traditional Birth Attendants	→ ↓				→ ↓	

### Key

Capacity to supply information or respond to sanction: Weak →; Medium ⇒; Strong ➡

Capacity to demand information or impose sanction: Weak ↓; Medium ⇓; Strong ↓

Members of CHSB are endorsed by the Ward Development Committee, after demonstrating interest to be members, and then assessed by the CHMT, before being recommended to the District Executive Director for appointment. However, one of the ward officials noted that the endorsement of non-state actors' representatives to CHSB does not take into account the ability of an individual to mobilize others to promote public interest:

'There was one person from this ward who completed the application form to be a member of the board, and we (ward officials) did approved it....Those positions (to be a CHSB member) are advertised and forms are usually made available at ward offices. We (ward officials) have to forward our recommendations to the district officials. It is very difficult to forward negative comments.....The only time we can deny an individual this position is when that person is mentally not normal' (Ward Official – Bagamoyo 2014).

Although the CHMT is very strong as it has personnel with strong biomedical skills and other resources to their disposal, they are more inclined towards public facilities. This is acerbated by the public distrust of the private sector, as a significant number of those who operate private practice are government employees. This was the response from one of key informants:

'The relationship with private providers is not well perceived by the public. There is a perception that they (public and private staff) favour each other. The main

argument is items are embezzled from the public facilities, and get sold in private facilities' (Elected District Official - Bagamoyo 2014).

Other key informants perceived that councillors' interests are focused on implementing their promises to voters in order to demonstrate their ability to hold the government accountable. This is perceived to dominate executive decisions at the district level, and further directing the CHMT and CHSB, which also has some CHMT members as board members, to focus on public facilities:

'The big role of the CHSB is to control procurement and distribution of drugs and other medical supplies at public facilities. The linkage between other committees and the CHSB is on how public complaints are conceived at lower levels and how they get channelled to the CHSB' (CHSB Member - Bagamoyo 2014).

There are wards where the Ward Health Committees do not exist, and in some other wards the Ward Health Committees do exist but are weak in terms of the PPP policy implementation as they have limited understanding of PPP as a concept or strategy:

'I would say our committee (Ward Health Committee) is non-functional, completely non-functional since last year. We tried to revive it but there were complaints among members about general skills development' (Ward Official – Bagamoyo 2014).

Village (Public Facility) Health Committees have limited scope and their main focus is on public facilities. Like all other committees, Village (Public Facility) Health Committees have limited capacity to demand information from non-state actors, and exercise oversight and sanctions:

‘My committee still requires skills development. There are a lot of issues that we don’t know. We are only two of us (me and the in-charge of the public facility in the village) who attended training at the district, and it was a brief session. You can not grasp everything in such a short training’ (Village Committee Chairman – Bagamoyo 2014).

#### **Strategic decisions to improve responsiveness: Limited inclusion of actors in planning and decision-making**

It was revealed by key informants that the CHMT prepares the Comprehensive Council Health Plan (CCHP) annually that has to be endorsed by the District Council Team before being approved by the Prime Minister’s Office – Regional Administration and Local Government (PMO-RALG) and the MoHSW. All relevant policies guidelines are provided by the MoHSW however, it was observed in this research that the private sector is not adequately represented in strategic decisions. The CHSB is not directly involved in strategic planning. Those whose names appear in the CCHP document as representative of non-state actors did not actually participate in strategic sessions, which limit inclusiveness of all services providers. These were responses of individuals whose names appear on the CCHP document as a representative of non-state actors:

**Table II:** *Types of partnerships with the local government that do exist in the district*

Type of Providers	Type of Contractual Agreement	Type of Collaboration
Faith-Based Provider	None	Provision of RCHS but excludes family planning. Supplies are provided free of charge, and staff are seconded from local government. In return services offered are free of charge.
Faith-Based provider	None	Informal arrangements at village level for staff availability.
Faith-Based provider	None	Informal arrangements between public facilities, and the private provider such as transfer of vaccines from one facility to the other during power blackout.
PFP and PNFP providers	None	Informal arrangements for assistance when a public facility runs out-of-stock such as for syringes, gloves, etc. Such assistance is usually free of charge but at times a replacement has to be sent at a later stage. Some private providers receive reagents for VCT.
Private pharmacies and faith-based providers	General Contract	Contractual arrangements between the NHIF and private providers, but restricted to pharmacies and faith-based providers. ADDO and private for profit are not part of providers' network.
Maternity home	None	Various forms of PPP arrangements with the maternity home such as outreach-point for immunization, free of charge supplies for some RCHS including PMTCT however, services are not entirely free, clients have to contribute and the contribution is determined by the provider.
Jointly operated facility, private estate company and government	None	The company provided a building, house for seconded staff, employ some staff, and procure and maintain a stock for its employees, while the government provides, supplies through its Integrated Logistics System for the community, and overall oversight of the facility, and second staff. RCHS are provided as per government guidelines.
Traditional Birth Attendant (TBAs)	None	There are some of facilities that have introduced incentives for TBAs who facilitate referrals of pregnant mothers for facility delivery.
NGOs	? MoU <sup>2</sup>	Partnership with NGOs (at local or national levels) in construction of staff houses, renovation of facilities, sexual and reproductive health initiatives, and HIV/AIDS prevention care and treatment initiatives.
Parastatal-based facilities	None	Parastatal-based facilities now operating like public facilities. Initially they had their own arrangements managed through their respective Ministerial headquarters.
Research Institute	MoU	Research project-oriented collaborations. The partnership is initiated at a time when the project is commissioned, and ends at the end of the project. It may involve construction and renovation of buildings, operating, and then transfer.
Out sourcing	None	In case of out-of-stock at the Medical Store Department. The district procurement officer would purchase a new stock from the appointed contractor, though the contractor tends to change each year.

<sup>2</sup> It was mentioned by key informants that MoUs do exist with NGOs, but the PI could not get access to these documents.



'I used to attend strategic meetings back in early 2000s as a representative of (non-state actors) but since 2005 after I took another job I stopped. So if you tell me I am still a representative, that is not right, I don't attend those meetings....' (Non-state Actor's Respondent – Bagamoyo 2014).

'I usually hear about it (CCHP). I have never seen a copy.....I don't understand why my name should appear in that document as a representative.' (Non-state Actor's Respondent – Bagamoyo 2014).

The local government is able to promote the Community Health Fund (CHF) membership as directed by the Ministry's guidelines. Room to improve physical access by engaging non-state actors however, is not well explored at the local level as they are less represented in strategic planning. In one of visited villages, the NFP provider is easily accessible and well equipped. Nevertheless, CHF members who also include secondary school girls cannot use that facility as CHF is restricted to public facilities. Members are required to walk a considerable distance to access care. When medicines are out-of-stock, which is the case in most public facilities in this district, they pay cash at private facilities or ADDOs:

'We (CHMT and CHSB) can make our decisions at the district level after receiving guidelines from the ministry however, for CHF members to receive services from private providers, we need to plan it well. We have to get them (private providers) sensitized. For now we have no options' (CHSB Member – Bagamoyo 2014).

Regarding district health data, data available from DHMIS, which was developed at the national level are analysed and discussed during the CHMT meetings. However, it was demonstrated by one of key informants that data collected are of poor quality, or those that are available are not digestible or actionable to improve PPP at the district level (see Mutale et al. 2013):

‘In one activity you may find you have twenty indicators. For example under DHMIS there are about eight reports. At the same time there are other reports required for each section such as RCHS, PPP, etc...this becomes an additional workload. There is no way you can get a good quality report’ (CHMT Member – Bagamoyo 2014).

There is still a perception that data collected are required by the Ministry, indicating non-use of data to address emerging challenges. For example, reports from one facility-based private provider indicate a high workload that does not match the number of staff available. However, little has been done to address this issue despite the fact that this facility receives subsidies from the government:

‘The government needs to find a way to support us. They (government) see our monthly reports. In a month, a number of under-fives attended here is between 1000 and 2000, new cases of pregnant mothers is between 70 and 80, leave alone “re-attendance”. For family planning, we report 200 clients. That is a very tough job...We really struggle to get staff. And I understand even at government facilities

there is a shortage, but there are ways we can work together on this' (Facility Manager – Bagamoyo 2014).

Limited inclusion of actors in planning and decision-making is also reflected on how logistics are managed. There is a lack of innovation to facilitate change as seen with Integrated Logistics System for supplies that come from the Medical Store Department as a fixed stock. There is limited flexibility to ensure the stock is constantly maintained and an alternative source is easily established with other local suppliers such as ADDO or other facility-based providers through PPP, when there is a shortage of supplies at public facilities:

'There are times you may receive the new stock from the Medical Store Department but since it is a fixed stock you may be in a situation where there is an increased need for a particular treatment. In such a situation it becomes very difficult to approach the company (the partner) for assistance...' (In-charge of a jointly (public and non-state actor) operated facility – Bagamoyo 2014).

### **Performance accountability: Poor performance of accountability structures**

The CCHP does outline health outcomes that need to be collectively achieved in the district. However, there is a weak accountability linkage structure among actors (Table I), which is limited to supplying information creating a room for non-compliance. More emphasis is given to individual service's entry to the market through registration and licencing (see Kumaranayake et al. 2000). The feedback provided to facility-based providers usually focus on gaps in quality of data collected and areas for improvement in

data collection only. It was noted by the principal investigator that a platform for explanation and justification, leading to dialogue between the two parties has not been created (see Brinkerhoff 2004):

‘There is no feedback provided once we have submitted our reports. We don’t discuss anything further. When you see the performance of Bagamoyo District as a whole, you just assume you were part of the success/ failure. ....and it is only when you are lucky to attend higher level meetings’ (Manager of a local NGO – Bagamoyo 2014).

Drugs shops and pharmacies provide family planning pills and some sell injectable contraceptives but performance accountability in this aspect does not fall under the district RCHS or PPP focal person. There is a separate reporting system that has been created for ADDOs and private pharmacies by the Pharmacy Councils - a regulatory body, which is centrally coordinated however, a lot of inconsistency of who complies and who does not was noted by the principal investigator. There is no evidence of the report that comes back to the district from the Pharmacy Council. For stand-alone private diagnostic laboratories, most of them are not registered and do not submit reports anywhere (Table I).

#### **Provision of public services: Lack of service level agreements**

It was mentioned by one of key informants that in order to comply with the requirement of establishing formal partnerships, the district is in the process of putting into place Memoranda of Understanding (MoUs) with facilities that receive subsidies from the

government. Another key informant further mentioned that programs that are not funded through the local government, such as those implemented by NGOs and research project-oriented type of collaborations, usually have contracts in the form of MoU. Nevertheless, the district has not signed SLAs with any non-state actor who receives subsidies from the government, as stipulated in the Health Sector Strategic Plan III (2009 – 2015) and Health Sector PPPs Policy Guidelines (Table II).

This poses inappropriate distribution of risks and rewards, limiting mechanisms that have the potential to promote public goals. For example it was mentioned by a key informant that the district hospital occasionally gets free supplies from private providers such as NFPs when they run out-of-stock, but NFP providers buy supplies from wholesalers, at a higher price when compared to the Medical Store Department. In such a situation NFP providers may adjust to cope with this new demand, and leave value-driven social services (see Green et al. 2002):

‘Occasionally, I have supported the district hospital with drugs when they run out of stock...We are not getting anything from the Medical Store Department (MSD). We buy our supplies from a wholesaler, but issue them free of charge. We also give to the district hospital for free’ (Manager of a local NGO – Bagamoyo 2014).

It was noted that a lack of written agreement at the service level contributes to misunderstandings between parties, and there are service interruptions that are experienced as a result. This was the case with PMTCT service provision where private providers receive subsidized ARVs and reagents from the government. But in order to

receive these supplies private providers have to submit their reports monthly, something that is not done consistently. This has created unhealthy relationship between parties as there are those government staff who are strict to this requirement and those who would issue ARVs and reagents without adhering to this requirement:

‘With private providers there is a challenge as there are those who provide incomplete data, and those who do not respond. For example data on HIV, we need that information as they (private providers) get subsidized reagents from the government, but you will find that they (private providers) provide incomplete information claiming that they buy other items using their own resources’ (CHMT Member – Bagamoyo 2014).

Faith-based providers are faced with limited resources, and the services that they would love to offer are not offered. In addition, they now charge for services which they would prefer not to charge. This is the case with National Health Insurance Fund (NHIF) contracts where members are requested to pay in cash when NHIF delays the reimbursement. Additionally, the in-charge of one of NFP providers indicated that the faith-based facility cannot start providing RCHS if the government would not provide staff:

‘...because we do not receive supplies from the government it is a problem. There are situations when we get stuck, and we notify our clients/patients (including those under NHIF) to contribute.... It is difficult to run a facility if you buy

something at TSH 20,000/- and be expected to sell it at TSH 3,000/-...' (In-charge of NFP Facility – Bagamoyo 2014).

## Discussion

It appears that there are several efforts being made to promote PPP and the private sector at the district level in Bagamoyo. However, findings from this study highlight that these efforts are not well-coordinated, and effective mechanisms have not been established as yet to tap resources from or for the private sector. Non-state actors are seen to be severely marginalized in district strategic planning.

The presence of non-state actors' representatives' names in the district strategic planning documents that do not have the authentic representation, brings to light the characteristics of actors who govern the decision-making process. As argued by 'public choice' theorists, this reveals the self-interest driven behaviour of local government officials and the use of 'power as thought control' to influence decisions of executive meeting at the district and national levels (see Buse et al. 2012). It can be argued that this is a barrier towards achieving health goals through PPP.

Boulenger et al. (2009), Chirwa et al. (2013), Green et al. (2002) and Osewe (2006) have highlighted that faith-based providers are usually involved in policy dialogues, as they seem to have a common goal with the government. Findings from this study however, indicate NFP providers are also not involved in decision-making at the district level. Although faith-based providers are usually relatively well organised in Tanzania (see Spreng et al. 2011), and have strong representation in policy dialogues at the national

level through their umbrella organisation – Christian Social Services Commission (White et al. 2013), in this case study they are weakly represented at a district level. This presents a different experience compared to districts with faith-based appointed district hospitals (see Boulenger and Criel 2012).

White et al. (2013) highlighted that local governments are expected to have a more decision-making power on how funds are spent and with what type of provider. This study however, reveals power unevenness between governing bodies at the district level. The CHMT is equipped with strong personnel with biomedical skills, and other resources, but perceives PPP narrowly. Study findings highlighted limited skills on budget technical and allocative efficiencies given competing priorities to improve systems performance. Similar findings on technical and allocative efficiencies are revealed by Musau et al. (2011), and White et al. (2013). The District Council Team is very strong and makes executive decisions; however, it is more inclined to the public than the private sector. The Council Team focuses more on how resources are channelled to public facilities in order to win voters' popularity rather than strategies that would improve efficiency, equity and quality of care. The CHSB has the potential to foster the engagement of non-state actors, however the CHSB is weak as it lacks resources for effective PPP implementation.

Restricted flexibility in spending is seen to deter prompt actions to address evolving population need such as collaborating with private providers to, establish new RCHS, and improve physical access to care for CHF members. This can also be attributed to a narrow local fiscal space, as more than 95% of the local total health expenditure is earmarked once the CCHP has been approved by the central government. However as argued by



White et al. (2013), if the local strategic planning capacity is strengthened, the basket funding is the largest source of flexible funding from the central government and could be used to improve efficiency.

Findings from this study highlight many weak performance accountability linkages. Brinkerhoff and Bossert (2013) and Brinkerhoff (2004) argue that the capacity to demand information (supply information) and institute (respond to) sanction and regulatory oversight are expected to bridge the gap in the information asymmetry between the principal-local government and agent-private providers. Study findings here indicate a wide gap in information sharing as the relationship that is seen is that of 'regulator and regulated type' (see Spreng et al. 2011). Relational elements dynamics such as commitment to shared values, high level of trust and interactive problem-solving are not perceived as centrally important by the local government officials in district planning, exacerbated by lack of dialogue with non-state actors.

Kumaranayake et al. (2000) in their study in Tanzania and Zimbabwe found that regulation of private providers is oriented towards individual services rather than health systems organisation and/or market-level challenges. Similar findings are seen in Bagamoyo district on how ADDO shops, private pharmacies, and stand-alone private diagnostic laboratories are regulated by bodies, which do not have a direct link to the DMO or CHMT, further reinforcing system's fragmentation. Peters et al. (2004) argue that engaging the private sector, in the form of information exchange and in planning may yield better results rather than regulation alone.

Findings from this study reveal different forms of collaboration between the local government and the private sector. However, partnerships with non-state actors are informal with exception of those not funded through the local government, which have MoUs in place. Itika et al. (2011) argue that PPP as a concept is narrowly perceived at the local level, which is confirmed in this study. However, the current strategy by this district to introduce MoUs for non-state actors who receive government subsidies reflects how policies are usually re-shaped and re-interpreted in unexpected ways by front-line bureaucrats thus directly affecting policy outcomes (see Kamuzora and Gilson 2007; Walker and Gilson 2004). It can be argued that local officials are familiar with the requirements of formal partnership, however they (local officials) have directed their interest to MoUs, which is a general contract and somewhat manageable with limited negotiation skills, contrary to SLAs which require complex technicality to make them effective. Lipsky (1980) argues that policy implementers tend to shape how a policy is translated into practice based on its relevance with their working routines, values and interests. Nevertheless, Palmer (2000) argues that contractual relations (such as MoUs) that provide for more flexibility require on-going analysis of contractual dynamics, in a context with a potential market failure. Such an effective coordination is lacking in Bagamoyo District.

The absence of written contractual agreements with current partnerships in this district highlights how collaborations with non-state actors are usually initiated at a local level. It is argued that such partnerships do not take into account the proper analysis of supporting structure (political, economic and social structures) as stipulated in the national PPP policy (PMO 2009) for effective implementation. When non-state actors

initiate partnership with the local government, which is the case for most current collaborations and those which are at the conceptual stage in Bagamoyo District, such collaborations tend to loose public interest as a result. As argued by Brinkerhoff and Bossert (2013) and Ssengooba (2010) using the agency theory, and supported by these findings, the local government may not have enough capacity to monitor non-state actors, who may decide to pursue their own interest.

Chirwa et al. (2013) argue that well designed SLAs can reduce disparity in services provision between the rich and poor and geographical distribution, and promote service use based on need, and not ability to pay. On the other hand, the lack of a SLA, which is an instrument in compensation-based contracting, may impede providers' behaviour that favours public interests (see Brinkerhoff and Bossert 2013). These study findings reveal non-state actors' 'moral hazards' as a result of inappropriate distribution of risk and rewards. These are restrictions on who should receive services based on their ability to pay, and not on need, by introducing cost sharing mechanism for RCHS that would have been provided partly free of charge or avoiding types of collaborations that would require provision of RCHS. Chirwa et al. (2013) in their study in Malawi highlighted similar findings. Such type of providers' behaviour is likely to affect equity on service delivery, and hinder the implementation of the PPP policy. Since this study focused on service organisation at the district level further studies could usefully look into central incentives and governing rules to promote PPP at local levels.

## Conclusion

Limited capacity to make choices that would improve health outcomes at the local level is highlighted to be a hindering factor of the national efforts to promote PPP. Provision of public services by private providers without SLAs is shown to limit the progress towards attaining health goals through PPP. Governing bodies' power unevenness as related to PPP between CHMT, CHSB and District Council team impede inclusiveness of the private sector in district strategic planning. CHSB is the only a higher governing body at the district level expected to have the private sector representation, however CHSB is not empowered to oversee the CHMT in strategic decision-making.

This case study provides insights on how to strengthen policy implementation at the sub-national level, and strengthen the district health systems as a result of PPP. This study's findings are likely to be applicable to other districts in Tanzania since the governance structure and the nature of non-state actors in Bagamoyo district are similar to those in other districts. As the role of the private sector to contribute to public social goal is increasingly gaining recognition in lower to middle income countries, this study underscores a need for new 'social contracts'.<sup>3</sup> These types of social arrangements should enable inclusiveness in decision-making in a decentralized health system, and support centrally coordinated national PPP initiatives.

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<sup>3</sup> Social arrangements underpinned by shared values and embedded in a broader society and economy (Bloom et al. 2008)

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## Appendices

**Appendix I (English version):** In-depth open-ended Interview guide with executive key informants.

### **Approach:-**

- Introduction to be done by the interviewer (who is the study PI) that has to include the purpose of the research
- Obtaining consent using form in Appendix IV.
- Consent form signed by the interviewee and interviewer.
- A social network sketch would be used as a tool to facilitate identification of actors' linkages/ interactions.

**Questions will be asked in an open-ended format, and will be framed around the following key concerns:-**

1. Please describe the key public-private partnerships that are important to your work  
a. (if none) What partnerships might strengthen your work?
2. How is the PPP in provision of RCHS considered in the Comprehensive Council Health Plan?  
a. What sort of directives do you receive from the central government related to PPP in RCHS?  
b. How do you go about implementing such directives?
3. In relation to RCHS provision, what is the district PPP accountability structure?  
a. In relation to accountability, is it limited to providing information, or goes to explanation and justification, leading to dialogue?  
b. How is non-performance related to PPP in RCHS identified and addressed?
4. How often has the local authority audited/inspected health facilities that provide RCHS, and pharmacies and Accredited Drug Dispensing Outlets involved in selling commodities for RCH?  
a. What has been the outcome after the audit/inspections?
5. What is the composition of the Council Health Services Board (CHSB)?  
a. How is the appointment for CHSB and other health committees' members being done and what is the period of service?  
b. How often do the CHSB and ward & village committees meet?
6. How are the SLAs initiated for RCHS services providers and programs?  
a. In aspects of RCHS where the SLA has demonstrated to be effective, was this centrally directed or was it a local innovation? Can you please explain?  
b. How has SLAs affected the working relationship?  
c. How has the SLAs affected the referral process?
7. Would you recommend further skills development in PPP concept at the district level?  
a. What aspects should the training focus?
8. Anything relevant to share?

## Appendix I (Swahili version): Interview Questions

**Maswali yote yatakuwa yanaulizwa kwa mfumo wa kumwezesha anayejibu kutoa maelezo, na yataulizwa kutoka katika mtazamo ufuatao:**

1. Tafadhali elezea ushirikiano kati ya sekta ya umma na sekta binafsi ambao ni muhimu katika kazi unayofanya?
  - a. (kama hakuna) Ushirikiano gani unaweza kuongeza ufanisi katika kazi unayofanya?
2. Ni kwa jinsi gani ushirikiano kati ya sekta ya umma na sekta binafsi katika kutoa huduma za afya ya uzazi na mtoto unachukuliwa katika mipango kina ya afya ya Halimashauri?
  - a. Ni maelekezo gani mnayopata kutoka serikali kuu yanayohusiana na ushirikiano kati ya sekta ya umma na sekta binafsi katika huduma za afya ya uzazi na mtoto?
  - b. Ni jinsi gani mnatekeleza maelekezo hayo?
3. Kuhusiana na afya ya uzazi na mtoto upi ni muundo wa uwajibikaji katika ushirikiano wa sekta ya umma na sekta binafsi wilayani?
  - a. Kuhusiana na uwajibikaji, je unaishia katika kutoa taarifa, au huenda mpaka hatua ya kutoa maelezo na uthibitishaji na kupelekea kuleta mijadala au mazungumzo?
  - b. Ni kwa jinsi gani matatizo ya kiutendaji yanayohusiana na ushirikiano wa sekta ya umma na sekta binafsi katika huduma ya afya ya uzazi na mtoto yameweza kutambulika na kushughulikiwa?
4. Ni kwa mara ngapi maofisa wa wilaya wamekagua vituo vya afya vinavyotoa huduma za afya ya uzazi na mtoto, maduka ya dawa na maduka ya dawa muhimu yanahusika na kuuza bidhaa kwa ajili ya afya ya uzazi na mtoto?
  - a. Nini matokeo ya ukaguzi huo?
5. Mchanganuo wa wajumbe katika bodi ya huduma za afya ya halmashauri (CHSB) ukoje?
  - a. Ni kwa jinsi gani uteuzi wa wajumbe wa CHSB na wajumbe wa kamati mbalimbali za afya unafanyika na kwa muda gani wajumbe wanakuwa katika huduma?
  - b. Ni mara ngapi bodi ya huduma za afya ya halmashauri (CHSB), na kamati za afya za kata na vijiji hukutana?
6. Ni jinsi gani makubaliano ya huduma kwa ajili ya afya ya uzazi na mtoto uwa yanaanzishwa?
  - a. Katika suala la afya ya uzazi na mtoto ambapo makubaliano ya huduma yameonyesha ufanisi, je hii ilikuwa ni maelekezo ya kutoka serikali kuu au ni ubunifu wa mamlaka ya wilaya? Unaweza elezea tafadhali?
  - b. Ni jinsi gani makubaliano ya huduma yameathiri mahusiano katika ufanyaji kazi?
  - c. Ni kwa jinsi gani makubaliano ya huduma yameathiri michakato ya rufaa?
7. Je ungependekeza mafunzo zaidi ili kuongeza ujuzi zaidi katika dhana ya ushirikiano kati ya sekta ya umma na sekta binafsi katika ngazi ya wilaya?
  - a. Ni masuala gani katika mafunzo hayo yawekewe mkazo?
8. Kuna jambo lolote husika ungependa kuliweka wazi?

**Appendix II (English version):** Interview guide with the chairman/ secretary of the District Council Team, Ward Development Committees, and Village Health Committees.

**Approach:-**

- Introduction to be done by the interviewer (who is the study PI) that has to include the purpose of the research.
- Obtaining consent using form in Appendix V.
- Consent form signed by the interviewee and interviewer.
- A social network sketch would be used as a tool to facilitate identification of actors' linkages/ interactions.

**Questions will be asked in an open-ended format, and will be framed around the following key concerns:-**

1. Please can you describe the composition of the health committee?
2. How is the appointment of health committees' members being done and what is the period of service and its relation to the local political processes?
3. How often do the CHSB and ward & village committees meet?
4. What partnership if any can you see between the local government and non-state actors?
  - a. How are you involved in such partnership?
5. How often has the local authority audited/inspected health facilities that provide RCHS, and pharmacies and essential drug shops that sell RCH commodities?
  - a. What has been the outcome after the audit/inspections?
6. What efforts are made to improve the referral process for both public and private dispensaries and health centres?
7. How is the relationship between public and private providers?
8. Anything relevant to share?

## Appendix II (Swahili version): Interview Questions

**Maswali yote yatakuwa yanaulizwa kwa mfumo wa kumwezesha anayejibu kutoa maelezo, na yataulizwa kutoka katika mtazamo ufuatao:**

1. Unaweza kuelezea mchanganuo wa wajumbe wa kamati za afya tafadhali?
2. Ni kwa jinsi gani uteuzi wa wajumbe wa kamati za afya unafanyika na ni kwa muda gani wanakuwa katika huduma, na mahusiano yake na michakato ya kisiasa wilayani?
3. Ni mara ngapi bodi ya huduma za afya ya halmashauri (CHSB), na kamati za afya za kata na vijiji hukutana?
4. Kuna uhusiano gani (kama upo) unaouona kati ya serikali na huduma zitolewazo na watu binafsi au mashirika?
  - a. Unashirikije katika mahusiano hayo?
5. Ni kwa mara ngapi maafisa wa wilaya wamekagua vituo vya afya vinavyotoa huduma za afya ya uzazi na mtoto, maduka ya dawa na maduka ya dawa muhimu yanahusika na kuuza bidhaa kwa ajili ya afya ya uzazi na mtoto?
  - a. Nini matokeo ya ukaguzi huo?
6. Ni jitihada gani zinafanyika kuboresha michakato ya rufaa kwenye zahanati na vituo vya afya vya umma na binafsi?
7. Utauelezeaje uhusiano ulipo wa watoa huduma kati ya walio chini ya serikali, na watu au mashirika binafsi?
8. Kuna jambo lolote husika ungependa kuliweka wazi?

### **Appendix III (English version): Interview guide with facility managers**

#### **Approach:-**

- Introduction to be done by the interviewer (who is the study PI) that has to include the purpose of the research.
- Obtaining consent using form in Appendix IV.
- Consent form signed by the interviewee and interviewer.
- A social network sketch would be used as a tool to facilitate identification of actors' linkages/ interactions.

#### **Questions will be asked in an open-ended format, and will be framed around the following key concerns:-**

1. Please explain who do you partner with, and who do you have a good relationship with?
2. In relation to RCHS provision, who are you accountable to?
  - a. In relation to accountability, is it limited to providing information, or goes to explanation and justification, leading to dialogue?
  - b. How do you handle any misunderstandings?
3. Have you ever seen a copy of the Comprehensive Council Health Plan?
  - a. How are the services you provide covered in the plans?
4. How often has the local authority audited/inspected your facility, and what was the outcome after the audit / inspections?
5. Among private providers do you have representation in the Council Health Services Board (CHSB)?
6. How are the SLAs initiated if any exist? Are you satisfied with SLA? Please explain.
7. Do you see any improvement in resource sharing such as in the referral process or use of medical technology between public and private facilities?
8. Anything relevant to share?

### Appendix III (Swahili version): Interview Questions

**Maswali yote yatakuwa yanaulizwa kwa mfumo wa kumwezesha anayejibu kutoa maelezo, na yataulizwa kutoka katika mtazamo ufuatao:**

1. Tafadhali elezea ni taasisi gani unashirikiana nazo na ipi katika hizo unamahusiano mazuri?
2. Kuhusiana na utoaji huduma za afya ya uzazi na mototo, wewe unawajibika kwa nani?
  - a. Kuhusiana na uwajibikaji, je unaishia katika kutoa taarifa, au huenda mpaka hatua ya kutoa maelezo na uthibitishaji na kupelekea kuleta mijadala au mazungumzo?
  - b. Ni kwa jinsi gani unaweza kushughulikia kutokuelewana/kutofautiana kunapotokea?
3. Je umeweza kuona nakala ya mipango kina ya afya ya Halimashauri?
  - a. Ni kwa jinsi gani huduma unazotoa zinawekwa katika mipango hiyo?
4. Ni kwa mara ngapi serikali za mitaa wamekagua kituo chako cha afya na nini matokeo ya ukaguzi huo?
5. Miongoni mwa watoa huduma binafsi, je unauwakilishi katika wajumbe wa bodi ya huduma za afya ya Halmashauri?
6. Ni kwa jinsi gani makubalino ya huduma yameanzishwa, kama yapo? Je umeridhika na makubaliano hayo ya huduma? Tafadhali elezea.
7. Je unaona maboresho yeyote katika kugawana rasilimali kama vile katika mchakato wa rufaa au matumizi ya teknolojia za matibabu kati ya vituo vya umma na binafsi?
8. Kuna jambo lolote husika ungependa kuliweka wazi?



## **Appendix IV (English version): Consent Form – For Key Informants and Facility Managers**

### **Introduction**

The Government of Tanzania is now implementing the PPP policy in the health sector aiming at ensuring public and non-state health providers including NGOs work towards the common goal, that is enabling everyone in the community obtain needed care. However, there could be barriers that hinder the implementation process. So, the purpose of this study is to try to understand the gaps, particularly in provision of RCHS in order to establish better ways that would make public and non-state actors work together to enhance the district health system performance and improve service delivery.

You are requested to participate in an interview that will take a minimum of 30 minutes. The interview will be conducted by me, and will start by making sure you are comfortable. You can use English, Swahili or both when responding or asking questions, depending on which language you are comfortable. I can also answer questions about the research that you might have.

Then, I will ask you questions about Public Private Partnership in provision of Reproductive and Child Health Services. The questions will be about family planning, antenatal clinic, delivery, immunization for children, and care for under-fives. We will also talk about decentralization, district strategic plan, various district health committees and various audits that have taken place in area of Reproductive and Child Health Services. These are the types of questions I will ask. I will not ask you to share personal beliefs, practices or stories, and you do not have to share any knowledge that you are not comfortable sharing.

The interview can take place in any venue of your choice and no one else but me and you will participate in that interview. If you agree, the entire interview will be voice-recorded, but you will not be identified by name in the script. The script will be downloaded and stored electronically in the computer, which can only be accessed with a password. The information recorded is confidential, and no one else except me will have access to the script. The script will be discarded after 90 days.

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, I do not wish for this to happen. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

There will be no direct benefit to you, but your participation is likely to help us understand how the district health system can contribute to effective implementation of

PPP policy in the health sector, and in return strengthen the district health system further.

You will not be provided any incentive to take part in the interview, but your time is highly appreciated. I will share the findings of this study with everyone through the District Medical Officer.

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You have a right to contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC) if you have any questions or concerns about your participation in this research: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)  
Tel: +27 21 406 6492.

This research has been approved by the Tanzania Health Research Ethics Review Committee under the National Institute for Medical Research (NIMR):

<http://www.nimr.or.tz/contact-us/> Tel: +255-22-2121400

**Consent Section:**

I \_\_\_\_\_ have been invited to participate in research about understanding systems barriers that hinder the implementation of public-private partnership policy in the health sector at the district level.

I have read the foregoing information, (it has been read to me). I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to participate in this study interview.

I also consent for the interview to be voice recorded (please tick inside the box)  
Yes ☐ No ☐

Signature of Interviewee \_\_\_\_\_

Date \_\_\_\_\_

I \_\_\_\_\_ confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

***A copy of this form has been provided to the participant.***

Signature of Researcher \_\_\_\_\_

Date \_\_\_\_\_

## **Appendix IV (Swahili version): Consent Form - For Key Informants and Facility Managers**

### **Utangulizi**

Serikali ya Tanzania sasa inatekeleza sera ya ushirikiano kati ya sekta ya umma na sekta binafsi kwenye sekta ya afya kwa lengo la kuhakikisha watoa huduma za afya ya umma na mashirika yasiyo ya umma ikiwa ni pamoja na mashirika yasiyo ya kiserikali, kufanya kazi kwa lengo moja ambalo ni kumuwezesha kila mtu katika jamii kupata huduma zinazohitajika. Hata hivyo, kuna uwezekano wa kuwepo vikwazo ambavyo huzuia mchakato wa utekelezeji. Hivyo lengo la utafiti huu ni kujaribu kuelewa mapungufu hasa katika utoaji huduma wa afya ya uzazi na mtoto ili kuanzisha njia bora ambazo zitawezesha umma na watu binafsi au mashirika yasiyo ya kiserikali kufanya kazi kwa pamoja ili kuimarisha mfumo wa afya katika wilaya na kuboresha utoaji wa huduma.

Unaombwa kushiriki katika mahojiano ambayo yatachukua takribani dakika 30. Mahojiano hayo yatafanyika kati yangu na wewe, na tutaanza kwa kuhakikisha kwamba uko radhi. Unaweza kutumia lugha ya Kiingereza, Kiswahili au zote mbili wakati wa kujibu au kuuliza maswali kutegemea lugha ambayo wewe umeridhia. Mimi pia ninaweza kujibu maswali kuhusiana na utafiti huu pale ambapo utakuwa na swali.

Pia ntakuuliza maswali juu ya ushirikiano kati ya umma na sekta binafsi katika utoaji huduma za afya ya uzazi na mtoto. Maswali yatakuwa juu ya uzazi wa mpango, kliniki za wajawazito, huduma za kina mama kujifungua, utoaji chanjo kwa watoto, na huduma za watoto walio na umri chini ya miaka mitano. Pia tutaongelea kuhusu kuhamisha madaraka kutoka serikali kuu kuja wilayani, mikakati mpango ya wilaya, kamati mbalimbali za afya za wilaya na kaguzi mbalimbali ambazo zilifanyika katika eneo la huduma za afya ya uzazi na mtoto. Haya ni aina za maswali nitakayouliza. Sitauliza masuala yanayohusu imani binafsi, mazoea, au hadithi, na huhitaji kuelezea ujuzi/maarifa au jambo lolote ambalo hutaridhia kufanya hivyo.

Mahojiano yanaweza kufanyika katika chumba chochote utakachochagua na hakutakuwa na mtu mwingine isipokuwa mimi na wewe tu ndio tutashiriki mahojiano hayo. Ikiwa utakubali na kuridhia mahojiano yatahifadhiwa katika kihifadhi sauti lakini hautatambulika kwa jina katika kihifadhi sauti hicho. Maelezo yote yatakayochukuliwa katika kihifadhi sauti yatahifadhiwa katika komputa ambayo kupata taarifa hizo lazima kutumia neno la siri. Taarifa iliyoandikwa itakuwa ni siri, na hakuna mtu mwingine isipokuwa mimi tu ndio nitakuwa na uwezo wa kutumia taarifa hizo. Taarifa zote zitakazowekwa katika kihifadhi sauti zitaondolewa baada ya siku 90.

Kuna hatari kwamba unaweza kutoa taarifa zako binafsi au za siri katika mahojiano, au kwamba unaweza kuhisi wasiwasi kuzungumza juu ya baadhi ya mada. Hata hivyo sitopenda hili litokee. Huhitaji kujibu swali lolote au kushiriki majadiliano pale ambapo unaona taarifa utakazo toa ni binafsi na hutojisikia vizuri kutoa taarifa hizo.

Hakutakuwa na faida ya moja kwa moja kwako, lakini ushiriki wako unauwezekano wakutusaidia katika kuelewa jinsi mfumo wa afya wa wilaya unaweza kuchangia utekelezaji wa sera ya ushirikiano kati ya sekta ya umma na sekta binafsi katika sekta ya afya, na katika kurejea kuimarisha mfumo wa afya wa wilaya zaidi.

Hakutakuwa na motisha katika kushiriki majadiliano, lakini ninathamini muda wako. Matokeo ya utafiti huu nitamshirikisha kila mtu kupitia Mganga Mkuu wa Wilaya.

#### **Maelezo ya Mawasiliano:**

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Una haki ya kuwasiliana na Chuo Kikuu cha Cape Town, Kitivo cha Sayansi ya Afya, Kamati ya Maadili ya Utafiti wa Binadamu, kama una maswali yoyote au wasiwasi kuhusu ushiriki wako katika utafiti huu: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms) Tel: +27 21 406 6492.

Utafiti huu umepitishwa na Kamati ya Uchunguzi wa Maadili ya Utafiti wa Afya Tanzania ambayo iko chini ya Taasisi ya Utafiti wa Afya (NIMR) Tanzania:  
<http://www.nimr.or.tz/contact-us/> Tel: +255-22-2121400

**Sehemu ya ridhaa:**

Mimi \_\_\_\_\_ nimealikwa kushiriki katika utafiti kuhusu kuelewa vikwazo katika mifumo ambavyo huzuia utekelezaji wa sera ya ushirikiano kati ya sekta ya umma na sekta binafsi kwenye sekta ya afya katika ngazi ya Wilaya.

Nimesoma maelezo yaliyotolea (yamesomwa kwangu). Mimi nilikuwa na nafasi ya kuuliza maswali kuhusu suala hilo, na maswali yote niliyouliza yamejibiwa na nimeridhika. Nakiri kushiriki kwa hiari yangu katika majadiliano ya utafiti huu.

Nakiri pia kukubali mahojiano yawekwe kwenye kihifadhi sauti (tafadhali weka alama ndani ya boksi) Ndivyo ☐ Hapana ☐

Sahihi ya Mhojiwa \_\_\_\_\_

Tarehe \_\_\_\_\_

Mimi \_\_\_\_\_ Nathibitisha kuwa mshiriki amepewa nafasi ya kuuliza maswali kuhusu utafiti huu, na maswali yote yaliyoulizwa na mshiriki yamejibiwa kwa usahihi na kwa kadri ya uwezo wangu. Ninathibitisha kwamba mshiriki hajashurutishwa katika kutoa idhini, na amepewa ridhaa kushiriki kwa uhuru na hiari.

***Nakala ya fomu hii imetolewa kwa mshiriki.***

Sahihi ya Mtafiti \_\_\_\_\_

Tarehe \_\_\_\_\_

## **Appendix V (English version): Consent Form – Chairman / Secretary of Committees**

### **Introduction**

The Government of Tanzania is now implementing the PPP policy in the health sector aiming at ensuring public and non-state health providers including NGOs work towards the common goal, that is enabling everyone in the community obtain needed care. However, there could be barriers that hinder the implementation process. So, the purpose of this study is to try to understand the gaps, particularly in provision of RCHS in order to establish better ways that would make public and non-state actors work together to enhance the district health system performance and improve service delivery.

You are requested to participate in an interview that will take a minimum of 30 minutes. The interview will be conducted by me, and will start by making sure you are comfortable. You can use English, Swahili or both when responding or asking questions, depending on which language you are comfortable. I can also answer questions about the research that you might have.

Then, I will ask you questions about Public Private Partnership in provision of Reproductive and Child Health Services. The questions will be about family planning, antenatal clinic, delivery, immunization for children, and care for under-fives. We will also talk about various district health committees and various audits that have taken place in area of Reproductive and Child Health Services. These are the types of questions I will ask. I will not ask you to share personal beliefs, practices or stories, and you do not have to share any knowledge that you are not comfortable sharing.

The interview can take place in any venue of your choice and no one else but me and you will participate in that interview. If you agree, the entire interview will be voice-recorded, but you will not be identified by name in the script. The script will be downloaded and stored electronically in the computer, which can only be accessed with a password. The information recorded is confidential, and no one else except me will have access to the script. The script will be discarded after 90 days.

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, I do not wish for this to happen. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

There will be no direct benefit to you, but your participation is likely to help us understand how the district health system can contribute to effective implementation of PPP policy in the health sector, and in return strengthen the district health system further.

You will not be provided any incentive to take part in the interview. However, you will be given TSH 10,000 (USD 6) for your time. I will share the findings of this study with everyone through the District Medical Officer.

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You have a right to contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC) if you have any questions or concerns about your participation in this research

[www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms) Tel: +27 21 406 6492.

This research has been approved by the Tanzania Health Research Ethics Review Committee under the National Institute for Medical Research (NIMR):

<http://www.nimr.or.tz/contact-us/> Tel: +255-22-2121400



**Consent Section:**

I \_\_\_\_\_ have been invited to participate in research about understanding systems barriers that hinder the implementation of public-private partnership policy in the health sector at the district level.

I have read the foregoing information, (it has been read to me). I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to participate in this study interview.

I also consent for the interview to be voice recorded (please tick inside the box)

Yes ☐ No ☐

Signature of Interviewee \_\_\_\_\_

Date \_\_\_\_\_

I \_\_\_\_\_ confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

***A copy of this form has been provided to the participant.***

Signature of Researcher \_\_\_\_\_

Date \_\_\_\_\_

## Appendix V (Swahili version): Consent Form– Chairman / Secretary of Committees

### Utangulizi

Serikali ya Tanzania sasa inatekeleza sera ya ushirikiano kati ya umma na sekta binafsi kwenye sekta ya afya kwa lengo la kuhakikisha watoa huduma za afya ya umma na mashirika yasiyo ya umma ikiwa ni pamoja na mashirika yasiyo ya kiserikali, kufanya kazi kwa lengo moja ambalo ni kumuwezesha kila mtu katika jamii kupata huduma zinazohitajika. Hata hivyo, kuna uwezekano wa kuwepo vikwazo ambavyo huzuia mchakato wa utekelezeji. Hivyo lengo la utafiti huu ni kujaribu kuelewa mapungufu hasa katika utoaji huduma wa afya ya uzazi na mtoto ili kuanzisha njia bora ambazo zitawezesha umma na watu binafsi au mashirika yasiyo ya kiserikali kufanya kazi kwa pamoja ili kuimarisha mfumo wa afya katika wilaya na kuboresha utoaji wa huduma.

Unaombwa kushiriki katika mahojiano ambayo yatachukua takribani dakika 30. Mahojiano hayo yatafanyika kati yangu na wewe, na tutaanza kwa kuhakikisha kwamba uko radhi. Unaweza kutumia lugha ya Kiingereza, Kiswahili au zote mbili wakati wa kujibu au kuuliza maswali kutegemea lugha ambayo wewe umeridhia. Mimi pia ninaweza kujibu maswali kuhusiana na utafiti huu pale ambapo utakuwa na swali.

Pia ntakuuliza maswali juu ya ushirikiano kati ya sekta ya umma na sekta binafsi katika utoaji huduma za afya ya uzazi na mtoto. Maswali yatakuwa juu ya uzazi wa mpango, kliniki za wajawazito, huduma za kina mama kujifungua, utoaji chanjo kwa watoto, na huduma za watoto walio na umri chini ya miaka mitano. Pia tutaongelea kuhusu kamati mbalimbali za afya za wilaya na kaguzi mbalimbali ambazo zilifanyika katika eneo la huduma za afya ya uzazi na mtoto. Haya ni aina za maswali nitakayouliza, sitauliza masuala yanayohusu imani binafsi, mazoea, au hadithi, na huhitaji kuelezea ujuzi/maarifa au jambo lolote ambalo hutaridhia kufanya hivyo.

Mahojiano yanaweza kufanyika katika chumba chochote utakachochagua na hakutakuwa na mtu mwingine isipokuwa mimi na wewe tu ndio tutashiriki mahojiano hayo. Ikiwa utakubali na kuridhia mahojiano yatahifadhiwa katika kihifadhi sauti lakini hautatambulika kwa jina katika kihifadhi sauti hicho. Maelezo yote yatakayochukuliwa katika kihifadhi sauti yatahifadhiwa katika komputa ambayo kupata taarifa hizo lazima kutumia neno la siri. Taarifa iliyoandikwa itakuwa ni siri, na hakuna mtu mwingine isipokuwa mimi tu ndio nitakuwa na uwezo wa kutumia taarifa hizo. Taarifa zote zitakazowekwa katika kihifadhi sauti zitaondolewa baada ya siku 90.

Kuna hatari kwamba unaweza kutoa taarifa zako binafsi au za siri katika mahojiano, au kwamba unaweza kuhisi wasiwasi kuzungumza juu ya baadhi ya mada. Hata hivyo sitopenda hili litokee. Huhitaji kujibu swali lolote au kushiriki majadiliano pale ambapo unaona taarifa utakazo toa ni binafsi na hutojisikia vizuri kutoa taarifa hizo.

Hakutakuwa na faida ya moja kwa moja kwako, lakini ushiriki wako unauwezekano wakutusaidia katika kuelewa jinsi mfumo wa afya wa wilaya unaweza kuchangia utekelezaji wa sera ya ushirikiano kati ya umma na sekta binafsi katika sekta ya afya, na katika kurejea kuimarisha mfumo wa afya wa wilaya zaidi.

Hakutakuwa na motisha katika kushiriki majadiliano, hata hivyo ninathamini muda wako na utapatiwa kiasi cha shilingi za kitanzania 10,000 kwa ajili ya usafiri. Matokeo ya utafiti huu nitamshirikisha kila mtu kupitia Mganga Mkuu wa Wilaya.

#### **Maelezo ya Mawasiliano:**

University of Cape Town,  
The Faculty of Health Sciences  
Human Research Ethics Committee  
E 52, Room 24, Old Main Building,  
Groote Schuur Hospital,  
Observatory, 7925  
Telephone: +27 21 406 6492  
Fax: +27 21 406 6411

Tanzania National Health Research  
Ethics Review Committee  
National Institute for Medical Research  
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Una haki ya kuwasiliana na Chuo Kikuu cha Cape Town, Kitivo cha Sayansi ya Afya, Kamati ya Maadili ya Utafiti wa Binadamu, kama una maswali yoyote au wasiwasi kuhusu ushiriki wako katika utafiti huu: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)  
Tel: +27 21 406 6492.

Utafiti huu umepitishwa na Kamati ya Uchunguzi wa Maadili ya Utafiti wa Afya Tanzania ambayo iko chini ya Taasisi ya Utafiti wa Afya (NIMR) Tanzania:  
<http://www.nimr.or.tz/contact-us/> Tel: +255-22-2121400

**Sehemu ya ridhaa:**

Mimi \_\_\_\_\_ nimealikwa kushiriki katika utafiti kuhusu kuelewa vikwazo katika mifumo ambavyo huzuia utekelezaji wa sera ya ushirikiano kati ya sekta ya umma na sekta binafsi kwenye sekta ya afya katika ngazi ya Wilaya.

Nimesoma maelezo yaliyotolea (yamesomwa kwangu). Mimi nilikuwa na nafasi ya kuuliza maswali kuhusu suala hilo, na maswali yote niliyouliza yamejibiwa na nimeridhika. Nakiri kushiriki kwa hiari yangu katika majadiliano ya utafiti huu.

Nakiri pia kukubali mahojiano yawekwe kwenye kihifadhi sauti (tafadhali weka alama ndani ya boksi) Ndivyo ☐ Hapana ☐

Sahihi ya Mhojiwa \_\_\_\_\_

Tarehe \_\_\_\_\_

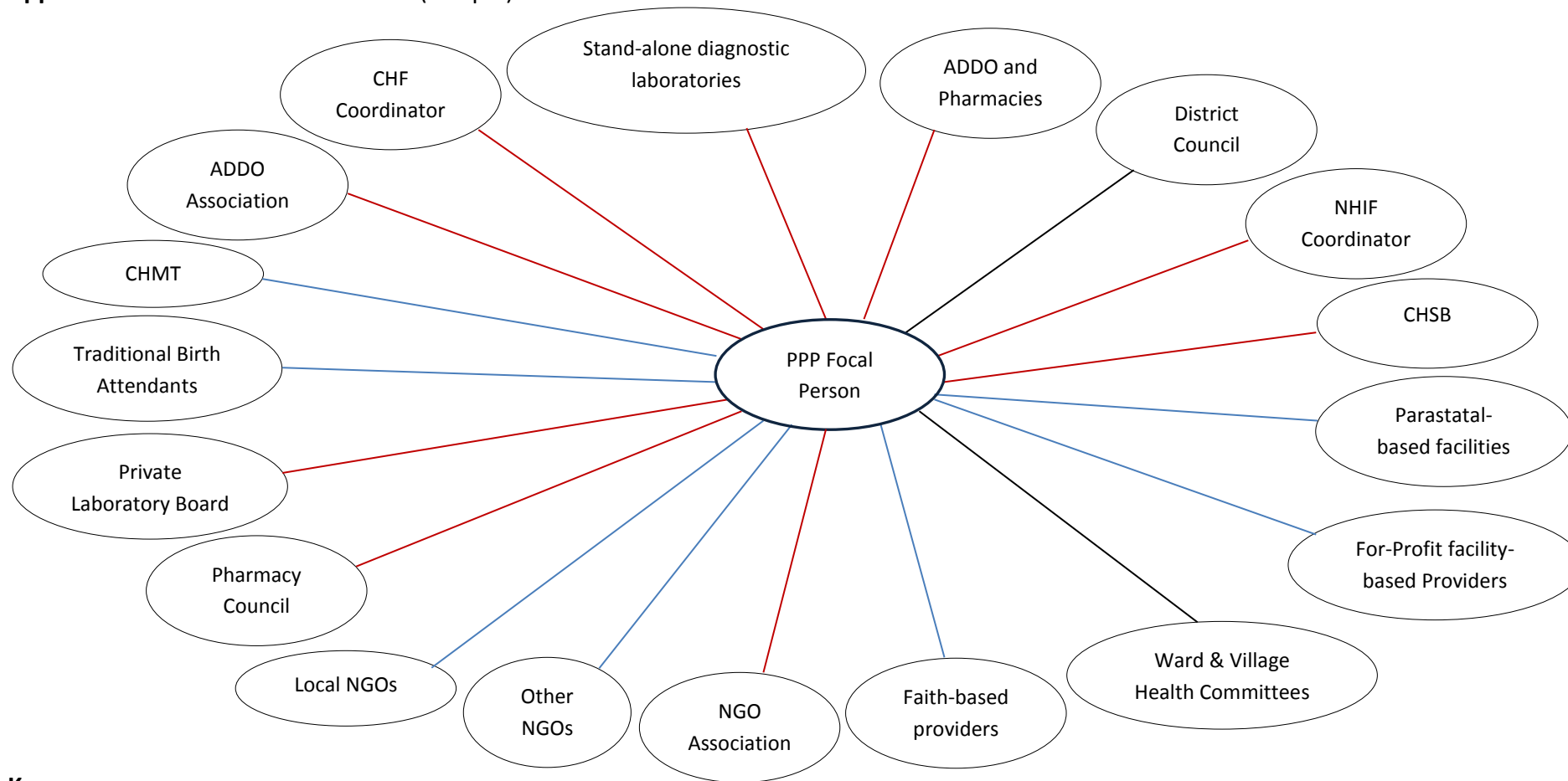
Mimi \_\_\_\_\_ nathibitisha kuwa mshiriki amepewa nafasi ya kuuliza maswali kuhusu utafiti huu, na maswali yote yaliyoulizwa na mshiriki yamejibiwa kwa usahihi na kwa kadri ya uwezo wangu. Ninathibitisha kwamba mshiriki hajashurutishwa katika kutoa idhini, na amepewa ridhaa kushiriki kwa uhuru na hiari.

***Nakala ya fomu hii imetolewa kwa mshiriki.***

Sahihi ya Mtafiti \_\_\_\_\_

Tarehe \_\_\_\_\_

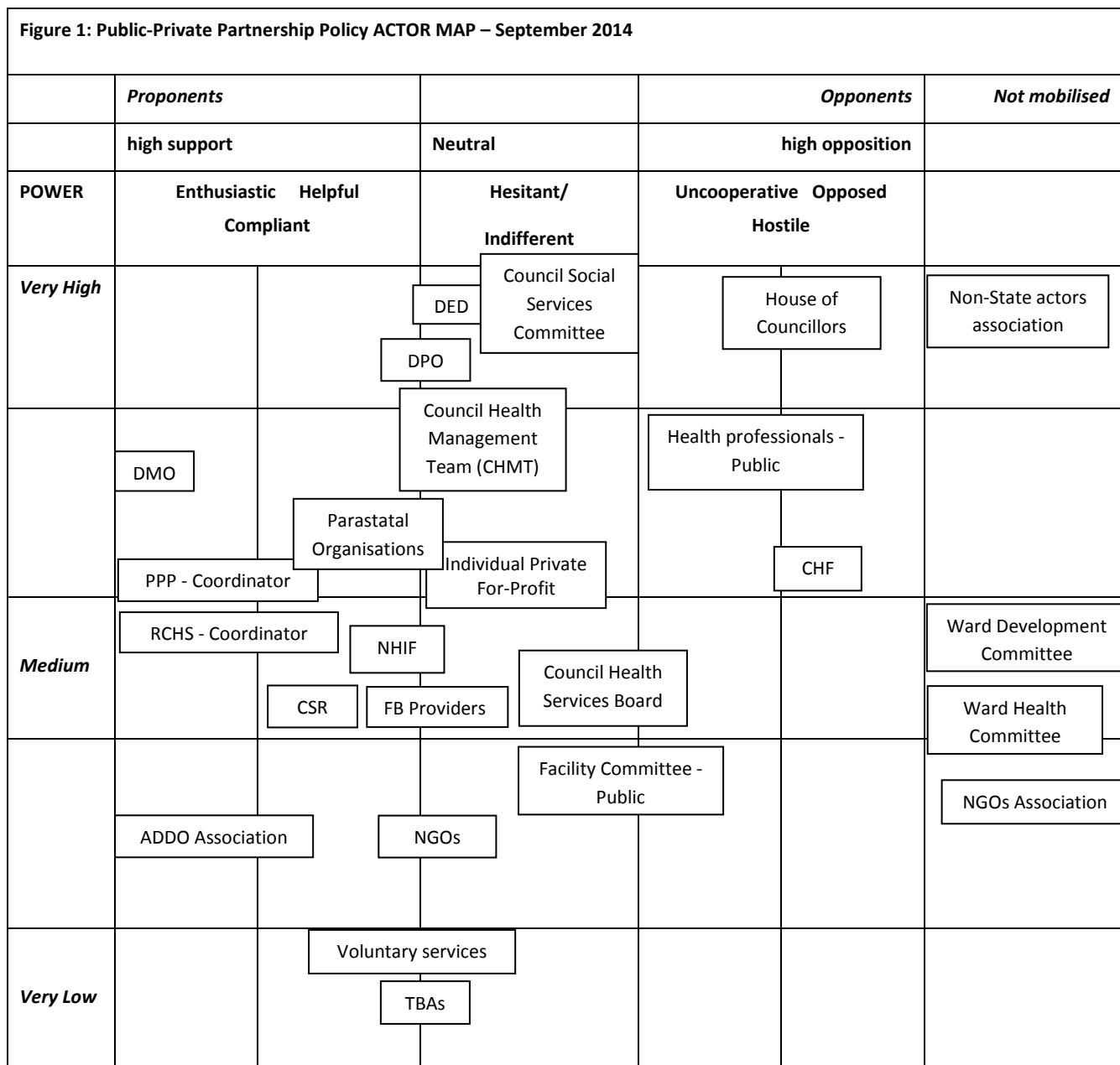
**Appendix VI: A social network sketch (sample)**



**Key:**

- Fairly good relationship
- Some improvement required
- Opportunity for a relationship (none currently exist)

## Appendix VII: Stakeholder map



## Appendix VIII: Data Source

Data Source	Quantity
Document review	<ul style="list-style-type: none"> <li>- Council Health Service Board and other committees guideline</li> <li>- Health facility monthly reports</li> <li>- ADDO reporting guidelines</li> <li>- PPP policy Guidelines</li> <li>- Memorandum of Understanding template</li> <li>- Service Agreement guideline</li> <li>- District Health Management Information System Inputs</li> <li>- Comprehensive Council Health Plan (CCHP) 2014/2015</li> <li>- CCHP planning guideline</li> <li>- Report to the House of Council</li> </ul>
Field notes	<p>Four observations</p> <ul style="list-style-type: none"> <li>- Informal discussions on referrals</li> <li>- Informal discussions on Community Health Funds</li> <li>- Interactions between clients and ADDO dispenser</li> <li>- Interactions between clients and staff at the private laboratory and pharmacy</li> </ul>
30 Individual Interviews	<ul style="list-style-type: none"> <li>3 - Accredited Drug Dispensing Outlets (ADDOS)</li> <li>2 - Pharmacies</li> <li>3 - Faith-based providers</li> <li>1 - Maternity home</li> <li>2 - Private for profit</li> <li>1 - Parastatal- based facility</li> <li>3 - Corporate Social Responsibility</li> <li>3 - Council Health Management Team (CHMT) members</li> <li>1 - Village/Facility Health Committee Chairman</li> <li>1 - Ward Health Committee Member</li> <li>1 - Council Chairman</li> <li>1 - Council Health Services Board Chairman</li> <li>1 - Council Health Services Board Member</li> <li>1 - NGOs</li> <li>1 - FBO representative</li> <li>1 - ADDOs Association Leader</li> <li>1 - RCHS Coordinator</li> <li>1 - PPP Coordinator</li> <li>1 - District Pharmacist</li> <li>1 - District Laboratory Technologist</li> </ul>

## Appendix IX: Journal Author Guidelines

### Information for authors

Health Policy and Planning's aim is to improve the design and implementation of health systems and policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. HPP is published six times a year.

HPP has a double-blinded peer-review policy. All papers, in each of the categories described below, are peer reviewed.

Specific objectives are to:

- Attract high quality research papers, reviews and debates on topics relevant to health systems and policies in low- and middle-income countries;
- Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;
- Encourage and support researchers from low- and middle-income countries to publish in HPP;
- Ensure papers reflect a broad range of disciplines, methodologies and topics;
- Ensure that papers are clearly explained and accessible to readers from the range of disciplines used to analyse health systems and policies; and
- Provide a fair, supportive and high quality peer review process.

Health Policy and Planning welcomes submissions of the following types: original articles, review papers, methodological musings, and research in practice, commentaries, and papers in our series' How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and '10 best resources' [for example, see David & Haberland, HPP, 20(4): 260-3].

Authors should pay close attention to the factors that will increase likelihood of acceptance. As well as the high overall quality required for publication in an international journal, authors should address HPP's readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health systems and policy issues and debates in low- and middle-income countries. Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected or returned to the authors for redrafting prior to being reviewed. In addition, economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.



Public health specialists writing about a specific health, policy, challenge or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made.

Manuscripts must be submitted online. Once you have prepared your manuscript according to the instructions below please visit the online submission website. Instructions on submitting your manuscript online can be viewed [here](#).

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by HPP. HPP discourages the submission of more than one article dealing with related aspects of the same study.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at [hpp.editorialoffice@oup.com](mailto:hpp.editorialoffice@oup.com)

During the online submission procedure, authors are asked to provide: a) information on prior or duplicate publication or submission elsewhere of any part of the work; b) a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest; c) a statement that the manuscript has been read and approved by all authors (see also section on authorship below); d) the name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript. The manuscript must be accompanied by copies of any permissions (see heading Permissions below) to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

All papers submitted to HPP are checked by the editorial office for conformance to author and other instructions all specified below. Non-conforming manuscripts will be returned to authors.

## **Authorship**

All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based on substantial contribution to conception and design, execution, or analysis and interpretation of data. All authors should be involved in drafting the article or revising it critically for important intellectual content, must have read and approved the final version of the manuscript and approve of its submission to this journal. An email confirming submission of a manuscript is sent to all authors. Any change in authorship following initial submission would have to be agreed by all authors as would any change in the order of authors.

## **Submission**

Please read these instructions carefully and follow them closely to ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions.

All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking [here](#).

## **Language editing**

All publications in the journal will be in English. Authors whose 'first' language is not English should arrange for their manuscripts to be written in idiomatic English before submission. If English is not your first language, before submitting your manuscript you may wish to have it edited for language. This is not a mandatory step, but may help to ensure that the academic content of your paper is fully understood by journal editors and reviewers. Please note that language editing does not guarantee that your manuscript will be accepted for publication. For further information on language editing services, please click [here](#). Several specialist language editing companies offer similar services and you can also use any of these. Authors are liable for all costs associated with such services.

## **Manuscript types and preparation**

- original articles
- review papers
- methodological musings
- research in practice
- commentaries

- papers in our series 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

### **Original research**

Manuscripts should preferably be a maximum of 6000 words, excluding tables, figures/diagrams and references.

The title page should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

## Statistics:

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Report simple analyses first, then only more sophisticated results.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (E.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as N (%), not just %.
- Report p values with 2 digits after the decimal, 3 if <0.01 or near 0.05. E.g., 0.54, 0.03, 0.007, <0.001, 0.048. Do not report p values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc)."

## Review articles

Manuscripts should preferably be a maximum of 10,000 words, excluding tables, figures/diagrams and references. Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. Systematic reviews are particularly welcomed, but may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review then the paper should explain why a systematic review was not feasible/ desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The title page should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Commentaries – Short commentaries on topical issues in health systems are welcomed. Most such commentaries are commissioned by the editors, but the journal will also consider unsolicited submissions. Commentaries should of broad interest to readers of Health Policy and Planning, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a maximum of 1200 words, excluding tables, figures/diagrams and references.

The title page should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

### **How to do...or not to do**

This series is meant to explain how to use a particular research or analytical method (e.g. social network analysis, discrete choice experiment etc.). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies.

Manuscripts should preferably be a maximum of 3000 words excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

The title page should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

10 best -is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health'

We often commission these articles but we also hear unsolicited suggestions.

### **Methodological musings**

This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion.

Manuscripts should preferably be a maximum of 3000 words, excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

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- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

### **Research in practice**

Research in practice provides an opportunity for researchers, policy makers and programme managers to reflect on their experiences of translating health policy and systems research into practice.

Manuscripts should preferably be a maximum of 3,000 words.

### **Manuscript format and style**

Only articles in English are considered for publication

Prepare your manuscript, including tables, using a word processing program and save it as a .doc, .rtf or .ps file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left

justified and not hyphenated.

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.



## Manuscript Preparation:

### Page 1: Title Page

- Please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

### Page 2: Abstract

Abstract should be prepared in one paragraph, with a limit of 300 words. No headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

### Page 3: Introduction

The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

- Materials and methods. The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses.
- Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.
- Discussion. The Discussion should be an interpretation of the results and their significance with reference to work by other authors.
- Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

## References:

References must follow the Harvard system and must be cited as follows:

Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics  
Volume number in bold: page numbers.

Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). Book title in italics.  
2nd edn. Place of publication: Publisher's name, page numbers.

Up to five authors should be cited. If there are more, cite the first three authors and follow with 'et al.', e.g.:

Baker S, Watts P, Smith B et al. 1993. Paper title in normal script. Paper presented at meeting/conference title, place, date. Unpublished document.

For more details, please consult the journal's mini style checklist.

## Tables

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